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ABSTRACT

The teaching guide and resource manual present information to help parents and other adults talk to children and adolescents about AIDS. The teaching guide is a resource for conducting parent AIDS education programs. It presents step-by-step instructions for facilitators that explain the activities and objectives and the teaching techniques for small groups who are learning about AIDS, communication techniques, risk assessment, and risk reduction skills. The resource manual presents information for both facilitators and participants of the program. Both the teaching guide and the resource manual have three chapters that include similar information. Chapter 1 provides specific facts about AIDS and HIV transmission and describes risk reduction methods. Chapter 2, "How To Talk to Kids about AIDS," presents ideas on communicating about AIDS and risk reduction with young people of various ages. Chapter 3, "Risk and Change," introduces ways of talking about and practicing risk reduction. The last section of the teaching guide lists resources for more information on AIDS and HIV services. A glossary of important terms is also included in both the guide and manual. (SM)

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Talking with Kids about AIDS: A Program for Parents and Other Adults Who Care

Teaching Guide [and] Resource Manual

Jennifer Tiffany
Donald Tobias
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TEACHING GUIDE

Talking with Kids about AIDS

A Program for Parents and Other Adults Who Care

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The companion volume to this teaching guide is *Talking with Kids about AIDS, Resource Manual.*

* * * *

This book is dedicated to Kathy Keris and Chris Gaillardet.

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INTRODUCTION

Why has Cornell Cooperative Extension developed an AIDS education project?

AIDS (Acquired Immune Deficiency Syndrome) will present a wide range of challenges to people during the 1990s. AIDS is caused by infection with HIV (Human Immunodeficiency Virus). People can learn to protect themselves from becoming infected with HIV, and because prevention of HIV infection is the only reliable way to stop the AIDS epidemic, prevention education will play a vital role in our response to AIDS.

The Talking with Kids about AIDS program was developed by Cornell Cooperative Extension and was first piloted in New York State. Prevention education programs are especially important in New York State because New York has more residents who have been diagnosed with AIDS than any other state in the United States. In fact, New York has more residents who have been diagnosed with AIDS than any country in the world other than the United States, although at least 169 countries already report citizens suffering from AIDS. According to state health department estimates, as many as 500,000 New Yorkers may already be infected with Human Immunodeficiency Virus. That is approximately one person out of every thirty-five residents of New York!

What do these numbers mean in human terms? They mean that in the coming years most of us will in some way be personally affected by the HIV epidemic. Most of us will know someone, work with someone, love someone, be related to someone, or *be* someone who has AIDS or HIV infection.

The AIDS crisis has generated many new services that provide prevention education. Existing service and information providers have mobilized to furnish AIDS awareness and prevention information to their constituencies. Cornell Cooperative Extension has a long history of helping individuals and communities to put research-based knowledge to work and a strong track record in working with young people, parents, and others who care about young persons. The Parent AIDS Education Project was developed as one way the Cooperative Extension network could mobilize its abilities to help cope with the AIDS crisis.

Contents of the Teaching Guide and the Resource Manual

The *Talking with Kids about AIDS Teaching Guide* is a resource for conducting programs for the Parent AIDS Education Project. The Introduction places the project in context and describes its goals, rationales, and philosophy.

Each of the following three chapters is a step-by-step teaching guide for the facilitator. They explain the activities and objectives and the teaching techniques used to conduct small groups who are learning about AIDS, communication techniques, risk assessment, and risk-reduction skills.

The *Resource Manual,* a companion volume to the *Teaching Guide,* provides the background information you need for conducting the Talking with Kids about AIDS program. Chapter 1, "What is AIDS?" provides specific facts about AIDS and HIV transmission and describes risk-reduction methods. Chapter 2, "How to Talk to Kids about AIDS," presents ideas on communicating about AIDS and risk reduction with young people of various ages. Chapter 3, "Risk and Change," introduces ways of talking about and practicing risk reduction. The last section lists resources for more information on AIDS and AIDS services. At the end of the manual, you will find a glossary of important terms.

How to use the Resource Kit

Read through this introduction. Then *carefully* read the chapters, "What is AIDS?" "How to Talk to Kids about AIDS," and "Risk and Change." Jot down any questions or comments you may have about this information. Then review the chapters outlining group sessions and teaching plans. You will practice these skills during your training as a volunteer.

Does AIDS Hurt? provides specific information on talking with young children about AIDS and HIV. Please read chapters 1 through 6 and chapters 12 and 13 carefully. They provide key information you will need for this program. The Cornell Cooperative Extension fact sheet series, "Resources for Parents and Others Who Care about Children," provides additional information on the growth and development of young people. The Center for Population Options fact sheet, "Adolescents, AIDS, and the Human Immunodeficiency Virus," provides specific information on risks young people may face for HIV infection.

Communication for Empowerment provides important information on group facilitation, logistics, and activities. Review this book carefully. You will have opportunities to discuss these materials and skills during your volunteer training.

Goals and objectives

The **goal** of the Parent AIDS Education Project is to save lives by reducing the spread of Human Immunodeficiency Virus (HIV), the virus associated with AIDS.

In the absence of a cure for AIDS or any technique for removing HIV from a person's system once infection has occurred, education promoting AIDS awareness and prevention is the most effective means of stopping the epidemic. The Parent AIDS Education Project has developed an educational program addressed to parents and other adults who care about and work closely with young people. As these adults understand key facts about AIDS and HIV and develop their own

skills as AIDS awareness educators, they will become increasingly effective in communicating information about AIDS and HIV prevention to young people. They will also become able to assess and reduce their own risks of sexual, drug-related, and work-related exposure to HIV.

Objectives of the Parent AIDS Education Project are closely related to its goal of using adult education to reduce the spread of HIV in our communities. Principal objectives of the project are

- *to increase participants' knowledge* about AIDS and HIV transmission;
- *to increase participants' coping skills* in relation to how AIDS is affecting their lives, their children's lives, and the life of their communities;
- *to motivate participants to reduce their own risk* of HIV infection;
- *to encourage participants to communicate* with young people about HIV/AIDS;
- *to support participants' ability to respond compassionately* to persons living with HIV or AIDS;
- *to increase participants' ability to complement school-based AIDS programs* by providing opportunities for discussion and additional learning about AIDS at home and in the community;
- *to enhance participants' skills as teachers and role models for young people* in relation to AIDS awareness, HIV-prevention skills, and responding compassionately to people living with HIV or AIDS;
- *to increase participants' skills as advocates* for development of accurate AIDS education programs and services in their communities; and
- *to maintain participants' membership in the Parent AIDS Education Program network* through ongoing community activities and volunteer educational opportunities.

Limitations of the program

While we're talking about the program's goals and objectives, it also seems important to state what the Parent AIDS Education Project does not seek to accomplish. While more intensive than many education programs, our curriculum cannot possibly teach everything there is to know about AIDS. It *will* help people to grasp key facts about AIDS and will present resources for further learning. Similarly, the program will present key skills in adult-child communication and will provide practice in communicating with young people about AIDS and HIV, with a focus on risk reduction.

This short program will address some, but not all, of the issues and concerns adults and young people face in relation to drug use, sexuality, and talking with one another. The program will address values and how parents may choose to talk with young people about values; it will not promote or impose a set of values. The role of the program is to provide resources in all of these sensitive areas. It is our hope that adult participants will leave the program better able to work at developing responses to these issues with and for the young people in their lives.

Why parents?

Parents, and other adults who care about young people, are in a unique position regarding AIDS education. In New York State and many other areas, the vast majority of persons diagnosed with AIDS are age 20 through 40. Many of the people who have been directly hurt by the first wave of the HIV epidemic are mothers, fathers, godparents, and other important people in children's lives. Even more people from this generation have known someone or had a loved one who became infected with HIV. These demographic facts alone make it vital that educational programs address the special needs of adults in their 20s, 30s, and 40s. Further, people in this age group make up the majority of parents and caregivers of school age and teenage children. Their care and day-to-day contact

with young persons make these people especially powerful role models and teachers.

AIDS and HIV infection are topics that many parents and youth workers find difficult to discuss. AIDS education involves talking about sexuality, drug use, and infectious illnesses. Discussions may include frank talk about topics that are considered taboo or very personal, such as condoms, homosexuality, the specifics of anal, vaginal, or oral intercourse, one's own sexual history, death and dying. Conversations between adults and young persons on such sensitive topics are always challenging. They may be even harder when parents feel they could have been at risk for HIV infection at some point in their lives or when someone they know has AIDS or HIV.

Talking about HIV risk reduction may also present difficult ethical issues: How do I tell my child how to keep safe from HIV infection while doing something I hope that he or she will not do? How do I state my own values? How do I make sure that I communicate *enough* accurate information so that my child is not at risk, in a way that my child will take seriously?

AIDS awareness and HIV prevention education cannot take place in a vacuum. The Parent AIDS Education Project was developed in New York State during the late 1980s, when as many as 500,000 New Yorkers (more than 2 percent of the state's total population) were already infected with HIV. Approximately 20 New York residents were being diagnosed with AIDS each day! AIDS education was critical if we were to cope with this situation and reduce the spread of HIV in years to come. In this context the project began working to develop a powerful adult education program. The program

- takes into account the real impact of AIDS and HIV on adult participants' lives;
- works with participants to transform this personal AIDS awareness into increasingly effective youth education skills;
- helps participants to articulate their own values regarding AIDS risk reduction so that these values inform and add power to their conversations with young people about AIDS and HIV prevention;
- encourages participants to practice telling young people about AIDS and HIV prevention, so that these difficult but important conversations happen more and more readily.

During the 1980s, New York State mandated school-based AIDS education. Many workplaces and community organizations also provide educational programs on AIDS. Relatively few programs directly address AIDS information to adults in terms of their important roles as caregivers and teachers of children and young people. Also, programs addressed to parents have tended to impart information about reducing their children's future risk for HIV infection without allowing time for participants to explore the current impact of AIDS on their own, their children's, and their communities' lives. Effective AIDS education must go deeper. The Parent AIDS Education Project seeks to involve participants more deeply in the AIDS education process by

- *offering a multisession, discussion-based curriculum* in which emphasis is on increasing, clarifying, and applying participants' knowledge about AIDS prevention;
- *encouraging small groups* and meetings located in homes and community centers;
- *encouraging access to groups* by provision of child care, transportation assistance, and group leaders who are peers of group participants;
- *emphasizing adult learning principles* such as challenging participants to take responsibility for their own learning, affirming the competence of participants, and focusing the information presented so that it is relevant to day-to-day needs and concerns of participants; and
- *tailoring sessions to specific group circumstances,* such as including specific information on the local impact of AIDS and focusing parent-child communication exercises on the age group of the young people group members work with most frequently.

Why kids?

Children and young persons are concerned about AIDS. It is a major element of the world that they are inheriting. It will potentially transform their views on sexuality, health, life, and death. It may transform their communities. It may have a direct impact on their families and loved ones. Young people are hungry to understand more about this disease and to learn ways they can live well and fully in a world where AIDS is a possibility.

Further, kids are at risk for HIV transmission. Repeated surveys demonstrate that a large majority of Americans engage in sexual intercourse while in their teens. This is true of all kinds of teenagers—inner city, rural, suburban, all from a wide variety of cultures and religions.

The majority of these teenagers do not use condoms consistently when they have intercourse. Rising rates of unplanned pregnancy and of sexually transmitted diseases such as syphilis and gonorrhea among teens document the real and potential risk of HIV infection to sexually active youth. If HIV is present in a sexually active teen population today, it is spreading. To make this risk very graphic: Any young woman who becomes pregnant also potentially is at risk of HIV infection.

A significant number of young persons use injectable drugs and may share needles. Needle-sharing during the injection of psychoactive drugs, steroids, or insulin can transmit HIV. Tattooing and ear-piercing may also involve shared needles.

Misinformation or confusing information presents an additional dimension of risk for HIV infection. Confusion arises when discussions focus on risk groups rather than on risk activities. The practice of labeling some persons (gay men/"faggots," IV drug users/"junkies," people who "sleep around") as especially at risk for AIDS may put teens at risk, for they usually view persons with such labels as "somebody else."

Teens are in the process of developing their own unique sense of self. Labels themselves may be threatening to young people's developing sense of identity. For example, a young man who has male lovers may not view himself as "gay." A young woman in her third long-term (six-month) steady relationship may view herself and her partner as "monogamous." An eighth grader who "skin pops" drugs knows that "IV drug user" means someone else. Young people must be told directly and concretely that they are at risk. Hearing that AIDS mostly affects members of high-risk groups may offer teens an easy out when it comes to personal risk assessment. It may make AIDS into "someone else's disease," and leave the young person still willing to act in ways that might transmit HIV.

While educational campaigns among gay and bisexual men have resulted in reduced sexual transmission of HIV and decreasing rates of other sexually transmitted diseases, campaigns addressed to young persons have not yet succeeded. Parents and other adults in close day-to-day contact with young people may be in the best position to understand young people's concerns and their risks for HIV infection, and they may be the most effective teachers of personal risk assessment and HIV prevention skills.

The final reason for a program encouraging adults to teach young people about AIDS is a positive one. When information is presented in the right manner at the right time, young people are often enthusiastic learners. They can adapt to new information and they can change their activities.

It is vital that young people get direct, specific information about activities that could put them at risk for HIV infection. We hope this book will help adults to learn to understand the age-specific learning abilities of children, the risk-reduction skills children may need, and the techniques for helping children to learn these skills.

Teaching philosophy

The Parent AIDS Education Project's approach assumes that AIDS has already had some impact on the lives of many people participating in this program. The program assumes that participants have special skills and insights regarding their children and that participants can develop creative ways of presenting appropriate AIDS education to their children. Also, although there are sources of misinformation, participants probably

already know a great deal about AIDS and HIV transmission. Through their caring and contact with young people, each participant is potentially a very influential AIDS educator. The program was developed to build on these strengths.

People need more than just facts, however, to carry out HIV prevention and AIDS information sharing in their lives. The program will help participants to work as a group to clarify any confusion they have felt about AIDS and to learn to offer AIDS information to young persons in increasingly effective ways. The group will act as a small "society" in which members will be encouraged to develop their skills in HIV prevention. This approach will assist participants to carry their new skills into day-to-day conversations and activities.

Program leaders act as facilitators and resource persons, helping participants to build their skills, confidence, and competence in relation to teaching children key facts about AIDS and HIV. Neither program leaders nor program participants need to become AIDS experts to be effective AIDS educators. It is important, though, that leaders and participants learn key facts about AIDS and be aware of sources of more information and services.

The Parent AIDS Education Project has been developed in the context of a number of Cornell Cooperative Extension programs that address and build upon participants' strengths to act effectively for change within their households, communities, and world. Participants in this program can make a difference. They can cope more effectively with the impact of AIDS on their communities. They can learn HIV prevention skills, and they can teach these skills to young people. They can have an impact upon the depth of AIDS information and HIV prevention education their children receive in schools. Their work will help to reduce the spread of HIV and possibly save the lives of people they love.

Content and format of the sessions

The "Talking with Kids about AIDS" program, as presented to parent groups, is divided into three sessions, two to three hours in duration. With some adjustment of activities, it can also be presented as one day-long workshop. Each session begins with a warm welcome and a review of the logistical arrangements, general agenda, and objectives for the meeting. In the second and third sessions, the first learning activity is a review of the "Challenge" or homework from the previous session. Each session presents a planned sequence of exercises and activities designed to accomplish the session's learning objectives. The first two sessions end with the Challenge activity to be done outside the workshop. Each session closes with an evaluation of the day's activities.

Each of the three sessions has a specific set of learning objectives. Objectives are spelled out in the teaching plan and shared with participants. Activities designed to help participants accomplish these objectives include brainstorming, round-robins, card-sorting and problem-solving exercises, breakout groups, general discussions, and other exercises. A good resource for the facilitator on the logistics and rules for various types of exercises can be found in the booklet, *Communication for Empowerment*.

A step-by-step guide for each group meeting is included in the chapter describing the session. This guide suggests what the facilitator should say to introduce each session and each activity, gives very specific directions for the exercises, and gives suggestions on timing the various parts of the activities. The guide is directed toward the newest facilitators and is a reliable tool for carrying out a successful session. As the facilitator becomes more experienced, the guide will serve as an outline to refer back to rather than strict instructions for what to say or do. In any case, the sequence of activities should be followed because each exercise builds on the material previously learned by the participants.

Information about the assumptions, resources, objectives, and preparation for each session is included in the teaching guide. These will help the facilitator understand exactly what learning is to take place during the session. For example, "Assumptions of the Session" states the teaching and learning philosophy upon which that particular session is based. The "Session Objectives" give the overall learning objec-

tives of the session. The "Exercise Objectives" tell what each activity or exercise is designed to achieve.

Finally, the "Preparation for the Session" and the "Resources for Session" help the facilitator to be thoroughly prepared to present the material. The guide gives a list of materials and a suggested room set-up. Reading material included in the resource kit will also be indicated.

Following the curriculum

Two vital elements of the Parent AIDS Education Program are 1) its respect for the strengths and competence of program participants, and 2) its clear focus on AIDS awareness and HIV prevention skills. For the program to keep its clear emphasis on AIDS and HIV information, it is important that facilitators follow the curriculum closely, without adding other teaching agendas. This approach will also help to demonstrate respect for the values of group participants, rather than assuming that participants share the facilitator's values and views on life.

It is sometimes tempting to try to cover a wide range of health-related topics in the context of HIV education, and there are many important topics related to sexual health and drug use. This program, however, requires that educators concentrate on HIV prevention information. One reason for this is the confusion people already may experience when they think about how HIV is and isn't transmitted. This curriculum has included specific information on HIV transmission and much opportunity for discussion. It is important that you, as a facilitator, be able to follow the curriculum and explain clearly and objectively which behaviors put participants at risk for HIV infection and which do not.

This program tries to use explicit language when describing risk for HIV transmission and specific prevention techniques. Vague phrases such as "sharing of bodily fluids" and "sexual contact" often leave people confused. Saying "IV drug abuse" when what puts people at risk for HIV infection is sharing needles and syringes is also confusing. "Unprotected intercourse" may be a meaningless phrase when condom use has not been explained. It is important that you be clear and specific in explaining what the risks are. The guide provides model phrases for you, and your volunteer training sessions will help you become increasingly comfortable with using frank and explicit language. You may want to practice using frank language by brainstorming a list of euphemisms or vague words about sex and drug use, then translating them into concrete language.

Who will come to the group sessions?

This program is for adults who care about, teach, work with, and are role models to children and teens. These adults may include parents, youth workers, guardians, aunts and uncles, big brothers and sisters, grandparents, and teachers. Possible organizations that could generate group members include workplaces, classes in schools or day care centers, clinics, churches and temples, community centers, unions, youth bureaus, local AIDS organizations, home and school associations, neighborhood associations, family planning associations, AA/NA/Alanon/recovery groups, tenants groups or housing associations. Think of a list for your own community. Brainstorm with other members of your team.

It may be especially effective to set up groups for people who already have some areas of affinity: teenaged mothers, parents of fourth-graders at Central Elementary, single mothers, divorced dads, parents of teens living on the 500 block of Cleveland Street, your friends, youth workers. As a facilitator, you may choose to tailor the curriculum to focus on special needs of people in these groups.

Part of your role as a member of the Parent AIDS Education project will be to organize and facilitate these small group sessions. Your willingness to organize groups among people you know, work with, or live near is important if the project is to reach the most people in the most effective way. Each of us has our own circle of affiliation—the people we know, talk to, work beside, and care about. It may feel risky to talk about AIDS to friends and coworkers, yet it may be an opportunity for you to offer them information that

literally may be lifesaving! Through your willingness to organize group discussions among people you know, you may also act as a role model and help them to take the risk of sharing AIDS awareness information with their children and other young people in your community. Be creative: Think of your many connections and of the many people you might help to understand AIDS prevention better!

How to plan and organize the sessions

Before you are ready to conduct the sessions, you will need to

- read this teaching guide and the resource manual thoroughly.
- attend a training program designed for volunteer educators.
- read supplemental materials in the program kit thoroughly. These materials include a book on talking with young children about AIDS/HIV called *Does AIDS Hurt?* and a book on organizing and facilitating groups called *Communication for Empowerment.*

After doing the background reading, attending the training sessions, and meeting with your team, you are ready to start planning to conduct a workshop series. You will need to

- pair up with another volunteer to plan and teach the series.
- decide on an audience for the current series.
- schedule three two- to three-hour meetings or one day-long meeting at a time and location that will be accessible to people in your audience (see *Communication for Empowerment).*
- get a commitment from seven to twelve people to attend the scheduled series.
- ask each of these people to try to bring a friend along to the series.
- arrange for child care and transportation if needed (see "Not another meeting!" and other sections of *Communication for Empowerment).* Schedule on-site child care to continue for 30–45 minutes after the meeting ends to allow parents of small children time for conversation after the meeting if they wish.
- arrange for refreshments (nice for 2-hour meetings; necessary for day-long meetings).
- duplicate the handouts you need.
- prepare other resource materials.
- ask for help from your teaching partner, your volunteer group, or Cooperative Extension staff in any areas where you need it.

Thank you for your participation in this project! If you have comments or questions regarding any part of this manual, please send them to:

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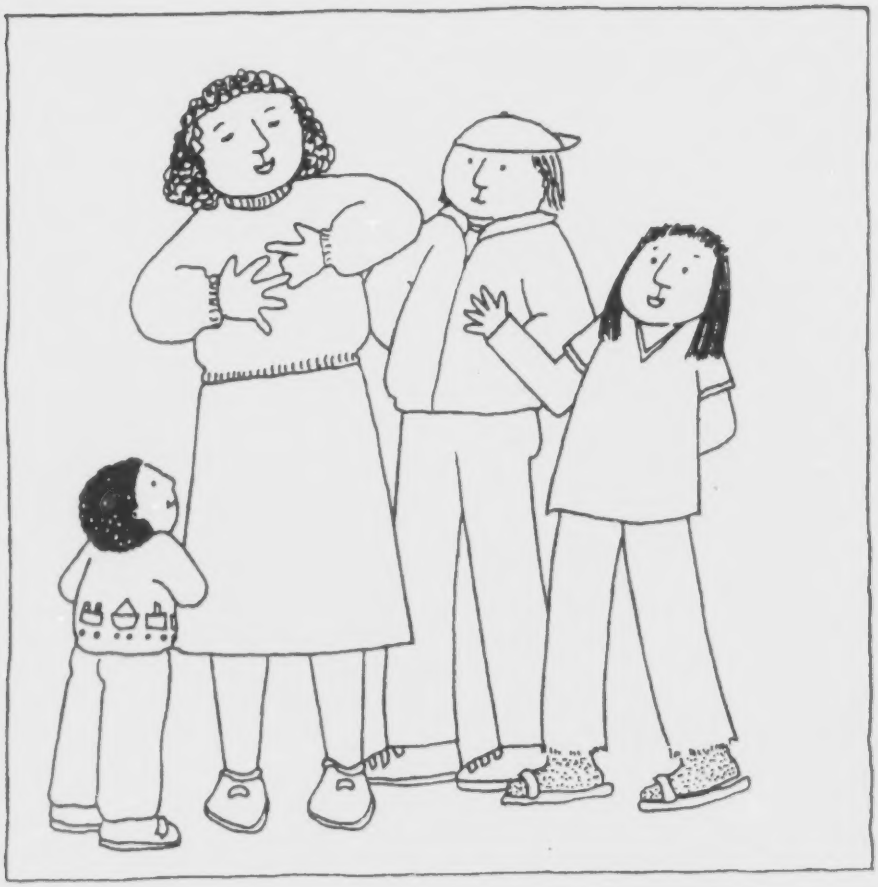

Explaining AIDS and HIV

Introduction to Session One

The first session of this workshop concentrates on basic facts about AIDS and HIV infection. It contains activities that clarify how HIV is and is not transmitted.

Because people learn most effectively when the information presented is directly related to their day-to-day lives, the first objective of the session is to challenge participants to see how AIDS is of concern to them. The session begins with an "AIDS Lifeline" exercise, which encourages participants to become aware of the past, current, and future impact of AIDS on their lives and on their communities.

In addition to increasing participants' knowledge about AIDS, Session One provides activities that support and develop their roles as teachers of prevention skills to young people. Participants develop a list of the facts they feel young people should learn about AIDS. The Challenge presented at the end of the session encourages participants to have an initial conversation about AIDS and HIV with their own children or other children.

Session One also contains a pretest, which is used to prompt a discussion of facts and misconceptions about AIDS/HIV.

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Session One preparation

Meet with your partner to review curriculum and to clarify who is responsible for what tasks.

Arrive at the meeting place 30–45 minutes before the scheduled start of meeting to set up the room and to greet people as they arrive.

Bring along the following materials

For each participant

Brochure: "How to Talk to Your Children about AIDS"
Pretest: Myths and Facts about AIDS
Sheet: "Basics about AIDS and HIV"
"Kids in My Life" brainstorming fact sheet
local resource list for community information
pencils and blank paper
pocket folders
name tags
newsprint for drawing a "Lifeline"

For workshop leader

agenda written on newsprint
blank newsprint
newsprint with the Challenge written on it
refreshments
card set for "What do we know about HIV transmission" activity
masking tape
markers
more pencils and blank paper
a large envelope for pretests

Set up chairs in a circle. Hang up agenda in front of Challenge sheet. Set up refreshments and a place for making name tags. If you haven't arranged them beforehand, put brochures, pretests, pencils, and blank papers into folders for each participant.

Assumptions of the session

This session assumes that participants already have useful knowledge about AIDS and HIV prevention. It also assumes that this information may be mingled with misconceptions. Participants may feel confused or overloaded with seemingly contradictory facts about AIDS drawn from the media or from peers. The session attempts to affirm participants' knowledge base and to provide them with a framework for putting their knowledge to work to promote risk reduction within their own lives.

A second assumption of the session is that AIDS has had some impact on the lives of participants. Participants or their loved ones may have some risk for HIV infection or may otherwise note the impact of the HIV epidemic on their community.

A third assumption is that participants have specific insights into the best ways to teach their children about AIDS and HIV risk reduction, both in terms of translating AIDS information into the family's value system and in terms of understanding their children's unique style of learning.

For background, be sure to read carefully Chapter 1 of the *Resource Manual,* "What is AIDS?" Skim Chapter 2, "How to Talk to Kids about AIDS," and Chapter 3, "Risk and Change." *Communication for Empowerment* provides specific group facilitation information. It is important that you understand the facts about HIV and prevention before you conduct your training sessions.

Session One objectives

1. Participants will become familiar with key facts about AIDS and HIV infection.
2. Participants will be able to explain why AIDS is a concern for them and their community.
3. Participants will be able to explain how HIV is and is not transmitted.
4. Participants will be able to identify ways in which AIDS/HIV may affect them as parents, guardians, youth workers, and so on.
5. Participants will be able to state several strengths that they have as teachers of young people.
6. Participants will begin to explore their role as AIDS/HIV prevention teachers of young people.

Session One exercise objectives

Kids in my life - Participants will become aware of their individual and collective ability to reach many young people with HIV prevention information. This is an empowering exercise.

AIDS Lifeline and Feeling Circle - Participants will be able to explain why AIDS is a concern to them and their community: Connects the AIDS epidemic directly to their own lives.

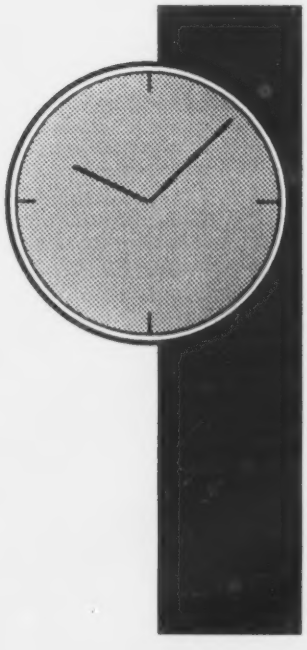
Myths and facts about AIDS - Participants will become familiar with key facts about AIDS and HIV infection: Corrects misinformation and confusion about AIDS and HIV.

What do we know about HIV transmission? - Participants will be able to explain how HIV is and isn't transmitted: Builds confidence in their knowledge about AIDS and gives practice in evaluating risks.

What do kids need to know about AIDS/HIV? - Participants will explore their role as AIDS/HIV prevention teachers of young people: Provides opportunity to outline information they want to impart to young people.

One strength I have is . . . - Participants can state their strengths as teachers of young people: Builds confidence in ability to teach and influence behavior of young people.

Tell your child . . . - Provides a safe beginning point in role of teacher of young people. Connects Session One to Session Two.



Agenda for Session One

Welcome	
Introductions and expectations	*20 minutes*
Brainstorm exercise: Kids in my life	*10 minutes*
Exercises: AIDS Lifeline and Feeling Circle	*30 minutes*
Pretest: Myths and facts about AIDS	*30 minutes*
Break	*15 minutes*
Exercise: What do we know about HIV transmission?	*30 minutes*
Brainstorm: What do kids need to know about AIDS?	*30 minutes*
Round-robin: One strength I have is . . .	*5 minutes*
Challenge for next week	*5 minutes*
Evaluation	*5 minutes*
Total time for session:	*3 hours*

Session One activities: Instructions for facilitators

Welcome

Greet participants as they arrive. Introduce yourself, learn their names. Give each participant a name tag (if you're using them) and a folder containing the brochure "How to Talk with Your Children about AIDS," a resource list for local AIDS information and support services, "The Basics about AIDS/HIV," and the pretest "Myths and facts about AIDS," as well as a pencil and some blank paper.

At the scheduled beginning time, **welcome people** and thank them for their participation.

Introductions and expectations

Introduce your personal interest in teaching about AIDS, and the overall goals of the series:

- To save lives by reducing the spread of HIV
- To build upon people's love for their kids and their skills as teachers so that they can teach kids about AIDS prevention

Review the key topics for the three sessions: learning about AIDS, learning about risk reduction, and communicating with kids about this information.

Point out where the refreshments and rest rooms are and tell people how long child care will continue.

Point out that the next two sessions will be held at the same time and location, and that child care (transportation assistance, refreshments, etc.) will be provided again.

Explain the ground rules of the group: "You are all here to learn and to solve problems. You may talk about some very personal and sensitive subjects, and it is important to always listen to one another and to treat one another with respect. It is very important that information and feelings that people share in this group be kept confidential. In other words, anything personal that someone says to the group shouldn't be talked about outside the group. Does the group agree to these ground rules?"

Review objectives and agenda for today's session: "Today, we'll discuss some key facts about AIDS and how it affects us and our communities. We'll learn how the virus that causes AIDS is and isn't spread, and what people can do to avoid getting infected. We'll talk about what kids need to learn about AIDS and how we can help to teach them. The pamphlets I gave you cover a lot of this material and give you the names and phone numbers of local groups that can provide more information. Let's start by introducing ourselves and telling why we're here."

Ask people to give their names and a brief introduction. After greeting everyone warmly, move on to the Brainstorm exercise.

Brainstorm exercise: Kids in my life

Ask participants to use the brainstorming scratch sheet to determine the number of kids they have at home or with whom they have regular contact. Give the group about two or three minutes to complete the sheet. Conduct a round-robin exercise and record the numbers on a sheet of newsprint labeled with the same categories. Assign one person to use a calculator and add up the numbers. Say to the group, "This is a very powerful group! All together we have the ability to influence and educate _____ young people about HIV prevention. Think about how many other young people these kids know."

This is a good way to get the group to think about their potential influence and how they might be able to reach more kids. It is a nonthreatening, brief, warm-up exercise that sets the stage for communication with kids.

Brainstorming scratch sheet: Kids in my life

At home

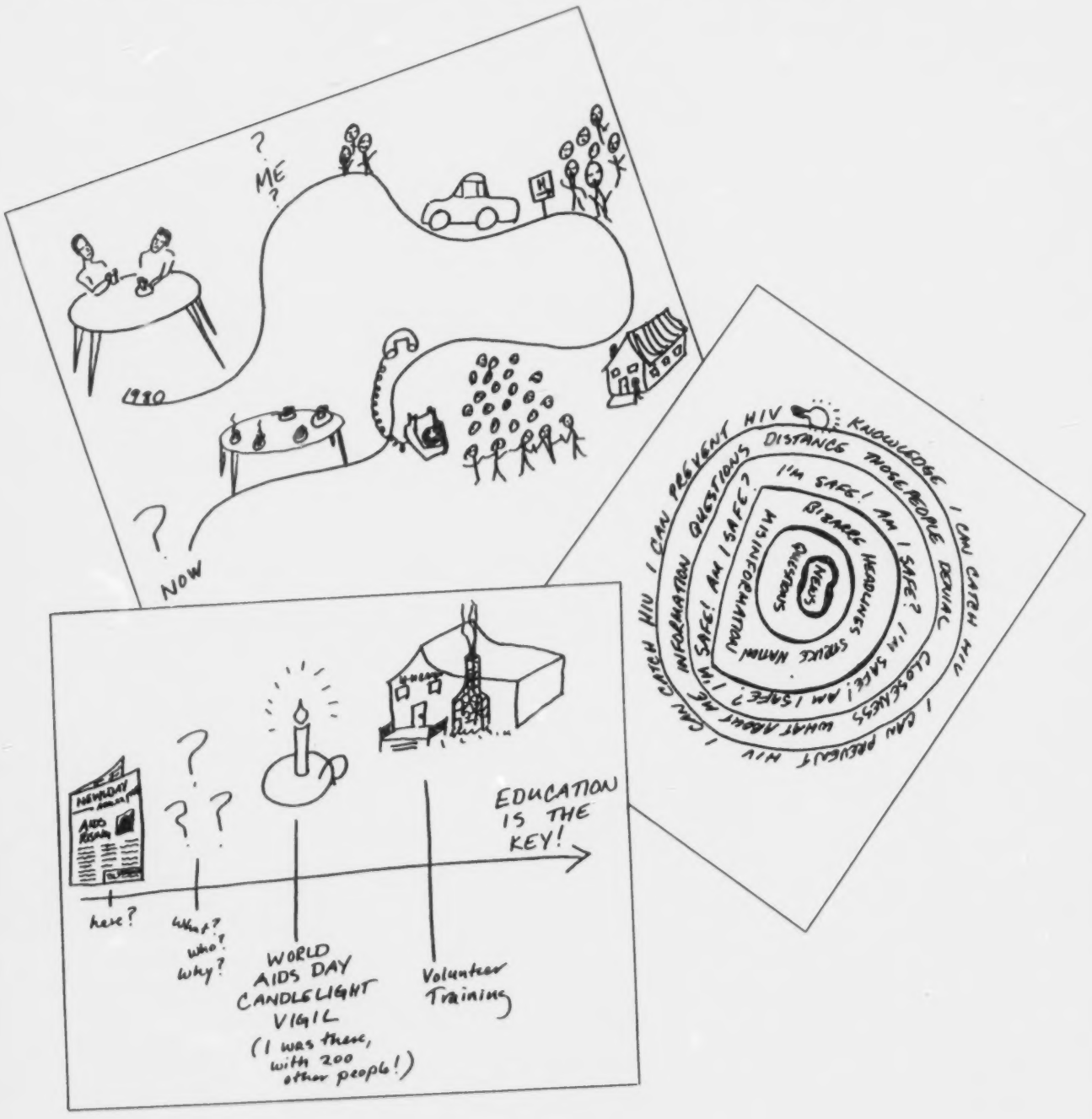
In my extended family of relatives and friends

In my community

At work

AIDS Lifeline Samples

"No two people have the same AIDS Lifeline. We all have thoughts and experiences we can share."



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Exercise: AIDS Lifeline*

Introduce the AIDS Lifeline exercise by stating that, in some way, AIDS has already had an impact on our lives. Go on to say, "This Lifeline exercise will help us examine the ways we are already living with AIDS so that we can understand how we can best teach young people how to live in a world where AIDS is a possibility."

Show sample lifelines. Ask people to relax and think about the series of questions, which you then read, leaving some silence after each one so that people can think about it.

When did you first hear about AIDS? What do you remember about your reaction?

Who did you first talk to about AIDS?

How have you learned about AIDS?

When did you first feel affected by AIDS personally? How did you react? How would you react now?

How is AIDS affecting your personal life in your community now?

How is AIDS affecting the lives of young people and children that you know? How are they reacting to it?

In what ways do you think AIDS may affect your life in the future? How do you think you may react?

*Adapted from "Working with Uncertainty: A Handbook for Those Involved in Training on HIV and AIDS," by Hilary Dixon and Peter Gordon, Family Planning Association Education Unit, 1987.

Then instruct participants:
"Take a moment to draw your AIDS lifeline on paper. The starting point of the lifeline can be anything you choose—your birth, the birth of your child, hearing about AIDS for the first time. You can draw any events or feelings in your life related to AIDS or HIV in any way you choose." The trainer may model this exercise by beginning to work on his or her own lifeline.

Take a few moments to draw the lifelines. Say to the group, "Now, find someone in the group to talk to about your two lifelines for the next few minutes. Make sure you each get a chance to talk. This is also a time when each of you can practice listening carefully and supportively to what someone else is saying."

After four or five minutes, ask partners to make sure that the second person takes some time to talk, if only one has talked so far.

After 10 minutes, draw the group back together.

Focus the discussion by using questions such as:

- Were there any feelings or experiences in your lifeline that your partner shared?
- What differences in experiences did you and your partner discover?
- Were you at all surprised by your own AIDS lifeline?
- How has AIDS changed your life and life in this community?

Continue this discussion for 10 to 15 minutes. Ask participants to keep their AIDS Lifelines in their resource folders. Introduce the Feeling Circle if you are going to use it.

Exercise: Feeling Circle

The Feeling Circle is a good icebreaker for groups where participants do not know each other. It feels safe. The Feeling Circle can be used as an introductory exercise replacing Lifeline; as a processing tool after Lifeline; or as an initial affective exercise with Lifeline somewhere else in the workshop schedule.

Draw a large circle on newsprint. Ask participants what feelings come to them when they talk about AIDS. To use the exercise as a processing tool, ask the group, "What feelings did the Lifeline exercise bring up for you?" Write down key words in the circle. Affirm the feelings expressed. When the circle is full of words, briefly review the wide variety of feelings AIDS brings up for people.

Pretest: Myths and Facts about AIDS

Introduce the Myths and Facts pretest.

Ask participants to take the Myths and Facts sheet out of their resource folders, and to spend a few minutes checking the answers they believe are true.

Explain that everyone knows a lot about AIDS, but also that there is a lot of misinformation around and people may feel confused.

Ask permission to keep copies of their pretests so that you can learn where people know correct facts and where people are confused, in order to plan other workshops.

After everyone has finished writing, pass around an envelope and ask people to put their tests in it.

Then initiate a discussion of the information.

Read each question out loud and ask people to say their answers out loud.

Discuss only those questions where participants expressed confusion or misinformation.

Congratulate participants as a group on what they already know.

Myths and Facts about AIDS

For each of these statements, circle "true" if you agree, "false" if you disagree, and "?" if you are unsure.

1. AIDS stands for Acquired Immune Deficiency Syndrome.	**True**	**False**	**?**
2. Infection with Human Immunodeficiency Virus (HIV) can lead to AIDS.	**True**	**False**	**?**
3. Blood, semen, and vaginal secretions from persons with HIV infection contain the virus.	**True**	**False**	**?**
4. People most often become infected with HIV by having sexual intercourse or sharing hypodermic needles with a person who already has the virus.	**True**	**False**	**?**
5. You *can't* get HIV from shaking hands, hugging, eating in restaurants, sharing dishes, or going swimming with someone who has AIDS.	**True**	**False**	**?**
6. A few people have gotten HIV from touching the tears or saliva of a person with AIDS.	**True**	**False**	**?**
7. You can tell someone has HIV by how they look.	**True**	**False**	**?**
8. Someone can be infected with HIV and not know it.	**True**	**False**	**?**
9. The HIV antibody test tells you whether or not you have AIDS.	**True**	**False**	**?**
10. Everyone who has HIV will get AIDS within two years.	**True**	**False**	**?**
11. Only IV drug users and gay men get AIDS.	**True**	**False**	**?**
12. Women can become infected with HIV if they have vaginal intercourse with a man who has HIV.	**True**	**False**	**?**
13. A woman with HIV can pass the virus to her baby before it is born.	**True**	**False**	**?**
14. Many children and teenagers could get HIV because they have sexual intercourse or shoot drugs.	**True**	**False**	**?**
15. Young people share needles for other purposes than shooting IV drugs, and this may be risky.	**True**	**False**	**?**
16. People can learn to keep from getting HIV.	**True**	**False**	**?**
17. New York State has more residents who have been diagnosed with AIDS than any other state in the country.	**True**	**False**	**?**

Myths and Facts about AIDS, Part 2

Please circle the correct answers to these questions.

1. What are some symptoms of AIDS or HIV disease?
   - **a.** Having a fever that lasts a month.
   - **b.** Losing one-tenth of your body weight without trying.
   - **c.** Having diarrhea that won't go away.
   - **d.** Sweating at night so much that your bedclothes are wet.
   - **e.** Having a dry cough and feeling short of breath.
   - **f.** Having "thrush" and/or vaginal yeast infections.
   - **g.** Losing your senses of direction and balance.
   - **h.** Having swollen lymph nodes (glands) for months.
   - **i.** All of the above.

2. How many people in the United States had been diagnosed with AIDS by December 31, 1992?
   - **a.** 1,000,000-1,500,000
   - **b.** 200,000-500,000
   - **c.** 253,448
   - **d.** 50,985

3. How many people in New York State had been diagnosed with AIDS by December 31, 1992?
   - **a.** 1,000,000-1,500,000
   - **b.** 200,000-500,000
   - **c.** 253,448
   - **d.** 50,985

4. How many U.S. residents probably are already infected with HIV?
   - **a.** 1,000,000-1,500,000
   - **b.** 200,000-500,000
   - **c.** 253,448
   - **d.** 50,985

5. How many New York State residents probably are already infected with HIV?
   - **a.** 1,000,000-1,500,000
   - **b.** 200,000-500,000
   - **c.** 50,985
   - **d.** 253,448
   - **e.** 1 to 3 percent
   - **f.** answers b and e

6. According to the World Health Organization, how many people worldwide probably become newly infected with HIV every day?
   - **a.** 1,000,000-1,500,000
   - **b.** 40,000-80,000
   - **c.** 5,000-6,000
   - **d.** None

7. What are some ways to reduce or eliminate sexual spread of HIV?
   - **a.** Abstinence from vaginal, anal, or oral intercourse.
   - **b.** Uninfected partners practicing monogamy.
   - **c.** Using latex condoms correctly during intercourse.
   - **d.** Practicing nonpenetrative sex.
   - **e.** All of the above.

8. How can someone keep hypodermic needles from transmitting HIV?
   - **a.** Not injecting drugs.
   - **b.** Not sharing hypodermic needles and syringes, ever.
   - **c.** Cleaning needles and works with bleach before using.
   - **d.** Using only sterile needles & works.
   - **e.** All of the above.

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The Continuum of HIV Infection and HIV Disease

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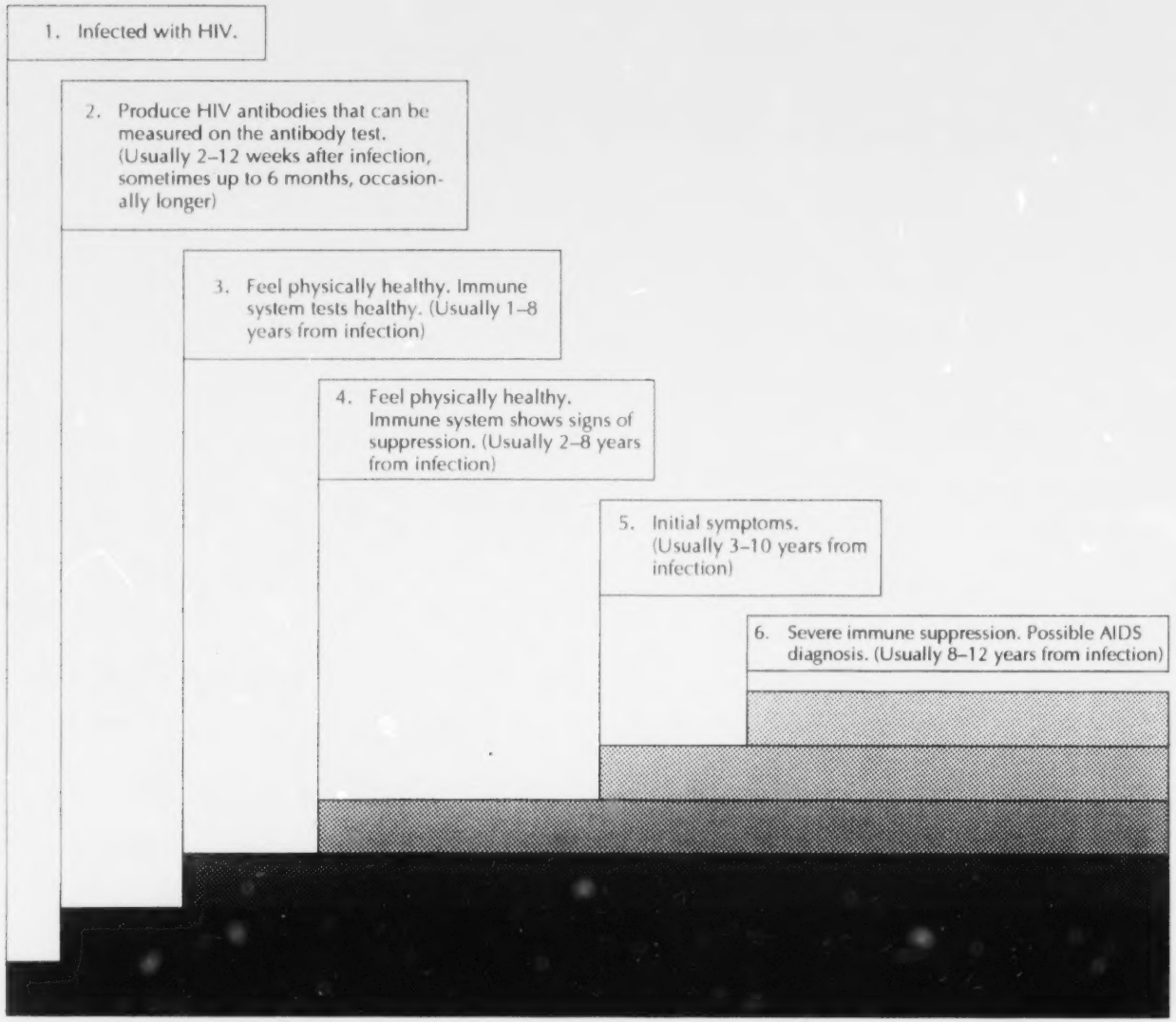

1. Infected with HIV.
2. Produce HIV antibodies that can be measured on the antibody test. (Usually 2–12 weeks after infection, sometimes up to 6 months, occasionally longer)
3. Feel physically healthy. Immune system tests healthy. (Usually 1–8 years from infection)
4. Feel physically healthy. Immune system shows signs of suppression. (Usually 2–8 years from infection)
5. Initial symptoms. (Usually 3–10 years from infection)
6. Severe immune suppression. Possible AIDS diagnosis. (Usually 8–12 years from infection)

Eleven years after infection, 341 members of the San Francisco cohort study were in the following phases of illness:

- 59% diagnosed with AIDS (49% deceased, 10% alive)
- 19% symptoms of illness
- 3% swollen lymph nodes but no other symptoms
- 19% no symptoms of illness

Myths and Facts about AIDS: Facilitator's key to information

1. **True.** *Acquired* means something people get, not something that they are born with. *Immune* refers to the immune system, the body's defense against diseases. *Deficiency* means that something is lacking—in this case, the immune system isn't working effectively. *Syndrome* means a combination of signs and symptoms, rather than one specific type of illness.
2. **True.** HIV infects important cells (T-4 Lymphocytes, also called Helper T cells) in the body's immune system and injures them. Over time, there are fewer working Helper T cells and the immune system can't protect the body effectively. When there are very few T cells left, the person may be diagnosed with AIDS, which means they have gotten serious diseases their immune system would have fought off if it was working effectively.
3. **True.** Blood, semen, and vaginal secretions from a person with the virus contain HIV. When the blood, semen, or vaginal secretions with HIV in it gets into another person's bloodstream or on their mucous membranes (inside the vagina, rectum, eyes, mouth and nose) the other person may get infected.
4. **True.** Most people who have HIV or AIDS caught the virus by having vaginal, anal, or oral sexual intercourse with someone already infected. Or else they shared injection needles with someone who had the virus.
5. **True.** HIV cannot be transmitted by these kinds of casual contact. Even the closer nonsexual contact that families have has not ever spread the virus.
6. **False.** No one has ever become infected with HIV by touching the tears, saliva, or sweat of a person who had the virus.
7. **False.** People with HIV do not look any particular way. They are just people.
8. **True.** Because people with HIV may not experience any symptoms at all, they may not suspect they have the virus.
9. **False.** This test only tells a person whether or not they have been infected with the virus. They may or may not develop symptoms of AIDS.
10. **False.** No one knows whether someone who has HIV will or will not develop AIDS. The average time between infection with HIV and symptoms of AIDS appears to be around 9 years.
11. **False.** Anyone (men, women, Asian, Hispanic, white, African-American, gay, heterosexual, born in the United States or elsewhere) can get HIV through sexual intercourse or needle-sharing.
12. **True.** Most young women with HIV were infected when they had vaginal intercourse with an infected man.
13. **True.** About one-third of babies born to women with HIV develop AIDS.
14. **True.** Most young people in America have had sexual intercourse before they are twenty. Many young people experiment with drugs and may share needles.
15. **True.** Sharing insulin needles, steroid needles, tattoo needles, skin-popping needles, or needles for earpiercing may be risky.
16. **True.** People can learn to reduce or eliminate risks of becoming infected with HIV. There are lots of success stories.
17. **True.** Almost one-fourth of U.S. residents diagnosed with AIDS live in New York State.

Answers to Part 2 of Myths and Facts about AIDS

1. **i.** All of the above
2. **c.** - 253,448
3. **d.** - 50,985
4. **a.** - 1,000,000–1,500,000
5. **f.** - 200,000–500,000 or 1–3 percent of the population
6. **e.** - 5,000–6,000
7. **e.** - All of the above are effective ways to prevent sexual transmission of HIV.
8. **e.** - All of the above are effective ways to prevent HIV transmission through needle-sharing.

Exercise: What do we know about HIV transmission?*

Introduce "What do we know about HIV transmission?" as a way to expand on this discussion and to build on the knowledge the group already has.

Briefly review how HIV is transmitted: Blood, semen, or vaginal secretions from a person with HIV contain the virus. These body fluids may have enough virus in them to cause infection if they get into someone else's bloodstream or on their mucous membranes (inside the vagina, rectum, nose, eyes, mouth). Reinforce the point that HIV is a weak virus, hard to acquire and easy to kill.

Start by placing three pieces of newsprint on the floor labeled "SOME RISK," "NEED MORE INFORMATION," and "NO RISK."

Hand out the set of cards face down and ask each person to pick a few cards until all are passed out. Instruct the group to figure out whether or not the virus could be transmitted by the activities the cards describe. Ask them to place each card where they think it belongs. When all the cards are placed, review the placements with the whole group. Ask participants if there are activities they are particularly concerned about that they may want to add to the cards. Quickly make cards for these and give them to participants to sort into the correct categories. Come to a consensus that all the cards are placed correctly. Provide any factual information needed to correct the placement of cards.

Read the resource chapter "What Is AIDS?" to refresh your ability to explain why tears are not something to worry about. Be prepared to hear that mosquitoes transmit HIV and to explain that this is untrue. Discuss the realistic level of risk in each situation where there is disagreement. If more fear is expressed about a situation than is realistic, ask the group to come up with the worst possible scenario for it, in which the factors necessary for transmission of HIV would be present. For example, having the group describe concrete ways someone might get HIV from a toilet seat makes it clear how unreasonable it is to expect that this might happen in the real world. Work to reach consensus within the group regarding all the cards. Do not at this time distinguish between levels of risk. If there is any risk at all involved in an activity, put the card into the "Some Risk" pile.

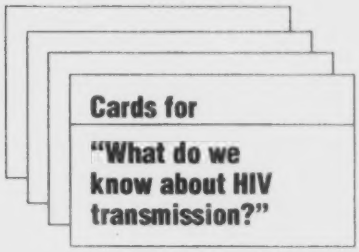
When the group has agreed on all the cards, move on to step two: Now sort the cards on "Some Risk" into three new categories. Place three new newsprint sheets labeled "High Risk," "Moderate Risk," and "Low Risk" on the floor. Define the terms by telling participants that in "High Risk" activities, blood, semen, or vaginal secretions from one person *will* come in contact with another person's mucus membranes or bloodstream (for example, vaginal intercourse without a condom). In "Low Risk" activities, this is still possible, but unlikely (for example, vaginal intercourse using a latex condom correctly).

The goal of the final sort is to end up with basic agreements that show understanding of the key facts of HIV transmission. It is neither necessary nor possible to list all activities in an exact continuum from least risky to most risky. Human behavior and sexuality have many variables that can not be reflected by the cards used in this exercise.

You might want to finish up this exercise by having the group talk about ways to reduce or eliminate the risks in activities sorted onto the "High Risk" pile. Tell them that they will have an opportunity to make new cards to add to the "No Risk" pile during the safer sex section of Safety Skills in the next workshop session.

Congratulate the group on its level of awareness and knowledge.

*Adapted from "Working with Uncertainty: A Handbook for Those Involved in Training on HIV and AIDS," by Hilary Dixon and Peter Gordon, Family Planning Association Education Unit, 1987.



* Deep Kissing
* Receiving a Blood Transfusion
* Masturbating Oneself
* Hugging
* Giving First Aid
* Vaginal Intercourse without a Condom
* Anal Intercourse without a Condom
* Vaginal Intercourse Using a Latex Condom Correctly
* Anal Intercourse Using a Latex Condom Correctly
* Being Sneezed On
* Sharing Needles
* Using Heroin
* Insect Bites
* Swimming at a Park
* Vaginal Intercourse Using a "Natural" Condom
* Oral Sex on a Man without a Condom

Smoking Crack in a Crack House and Wanting to Get More

Getting Drunk and Picking Up a Stranger

* A Man and a Woman Having Sex
* Two Women Having Sex
* Two Men Having Sex
* A Married Couple Having Sex
* Masturbating One's Partner

Smoking Crack Alone in Your Room and Staying There

Sharing a Toothbrush

Having a Cavity Filled

* Sharing School Books
* Using Insulin
* Sharing a Drinking Glass
* Using a Sterile Needle and Syringe to Inject Heroin
* Cleaning Dirty Works with Chlorine Bleach, Then Using Them to Inject Heroin

Interviewing Someone Who Has Shot Drugs I.V.

Sharing a Bath Towel and Wash Cloth

Spilling a Urine Sample on Your Knee

Sharing a Toilet

* Two Uninfected People Having Intercourse without a Condom

Giving a Massage

* Donating Blood

Watching Partner Masturbate

Giving Someone a Ride to the Doctor's Office

Sharing a Razor

Having a Kidney Transplant

Delivering a Baby

* Oral-Anal Sex (Kissing the Anus) Using a Latex Barrier
* Oral Sex on a Woman Using a Latex Barrier
* Oral Intercourse on a Man Using a Latex Condom
* Sharing a Syringe to Inject Insulin
* Sharing Works to Inject Heroin I.V.
* Sharing a Syringe to Inject Steroids
* Oral Sex on a Woman without a Latex Barrier

Getting Tattooed

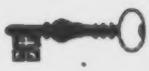
Piercing Ears

Using Semen for Artificial Insemination

* Being Heterosexual
* Being Homosexual/Gay/Lesbian

Selecting cards

We recommend that you make cards for all the starred (*) activities. Make cards for some of the other activities if you want or make cards tailored to concerns in your group or community.



What do we know about HIV transmission: Facilitator's key

For information on how HIV can be transmitted, read the chapter, "What Is AIDS?" in the *Resource Manual.* Situations not specifically discussed there are covered here.

Deep Kissing (No risk)
No one has become infected with HIV by kissing a person who has the virus. Deep kissing raises the issue of saliva. Scientists have been able to isolate HIV in some samples of saliva from people who are infected. Very little virus has been found in the saliva and much of it has been broken pieces of virus, unable to cause infection even if it got into someone's bloodstream.

Receiving a Blood Transfusion (Some risk—low)
All donated blood has been carefully screened for HIV antibody since mid-1985. The *Journal of the American Medical Association* reports the incidence of HIV in donated blood to be 1:39,000.

Masturbating Oneself (No risk)

Hugging (No risk)

Giving First Aid (Need more information)
If a first responder is splashed with blood in the face or eyes or accidentally stuck by a needle or other object that has infected blood on it, the person risks becoming infected. The Centers for Disease Control suggests that the likelihood of becoming infected after this kind of accidental exposure to HIV is about 1 in 200. Mouth-to-mouth resuscitation normally does not involve exposure to the patient's blood. Most first responders are now given equipment that prevents any exposure to blood during mouth-to-mouth resuscitation.

Vaginal Intercourse without a Condom
(Some risk—high)
See "What Is AIDS?" chapter in the *Resource Manual.*

Anal Intercourse without a Condom (Some risk—high)
See "What Is AIDS?" chapter in the *Resource Manual.*

Vaginal Intercourse Using a Latex Condom Correctly
(Some risk—low)
If the condom is used correctly from start to finish, the risk is low. *Consumer Reports* tested condoms and found American-made name-brand latex condoms to be 97–99 percent effective. See "What Is AIDS?" chapter.

Anal Intercourse Using a Latex Condom Correctly
(Some risk—low)
If the condom is used correctly from start to finish, the risk is low. *Consumer Reports* tested condoms and found American-made name-brand condoms to be 97–99 percent effective. See "What Is AIDS?" chapter.

Being Sneezed On (No risk)
HIV can't be spread this way, though colds can.

Sharing Needles (Some risk—high)
Sharing needles is a very efficient way to transmit HIV. See "What Is AIDS?" chapter.

Using Heroin (Need more information)
If needle and works aren't shared, there is no risk. It is the shared equipment, not the type of drug, that presents danger of HIV infection.

Insect Bites (No risk)
In Central Africa, where there are many biting insects, babies whose mothers have HIV, children who have received blood transfusions for malaria, and sexually active people are infected with HIV. Other people are also bitten by insects, but do not have HIV.

Using Insulin (Need more information)
No risk unless the needle and syringe are shared. If they are shared, then it is risky.

Getting Tattooed (Need more information)
No risk unless the tattooing needle is shared. But in some situations—prisons, for example—many people may share one unsterilized needle. This is risky.

Piercing Ears (Need more information)
No risk unless the needle is shared.

Swimming at a Park (No risk)

Vaginal Intercourse Using a "Natural" Condom
(Some risk—high)
Natural condoms are not an effective barrier. They are made of sheep intestine lining, which has pores large enough to allow HIV to pass through.

Oral Sex on a Man without a Condom
(Some risk—moderate to high)
If pre-ejaculate or semen containing HIV enters the mouth, the virus can infect the cells of the mucous membrane lining the mouth whether or not there are cuts, sores, or abrasions.

Smoking Crack in a Crack House and Wanting to Get More (Need more information)
Smoking crack does not transmit HIV. It does impair judgment, however, which may lead to risky behavior. Sometimes risky sexual favors may be traded for the drug.

Getting Drunk and Picking Up a Stranger
(Need more information)
The potential for HIV transmission depends upon what one does with the stranger. Being drunk may make people less apt to use safety precautions or make good decisions.

Two Women Having Sex (Need more information)
The potential for HIV transmission depends upon how they have sex.

Two Men Having Sex (Need more information)
The potential for HIV transmission depends upon how they have sex.

A Man and a Woman Having Sex
(Need more information)
The potential for HIV transmission depends upon how they have sex.

A Married Couple Having Sex
(Need more information)
Marriage does not ensure monogamy and one partner could have become infected with HIV by someone else before or during the marriage through sexual or nonsexual routes.

Masturbating One's Partner (No risk/low risk depending on situation described by participants)
The only way masturbating one's partner could transmit HIV would be if there were cuts on the hand that was masturbating and semen or vaginal secretions entered the bloodstream through the cuts.

Smoking Crack Alone in Your Room and Staying There
(No risk)
You cannot give HIV to yourself.

Sharing a Toothbrush (Some risk—low)
Blood could remain on the toothbrush.

Having a Cavity Filled (Some risk—low)
Dental work does not spread the HIV virus unless both the patient and the dentist get injured with the same implement.

Sharing School Books (No risk)
HIV does not live on objects like books.

Sharing a Drinking Glass (No risk)
Saliva does not transmit the virus from person to person.

Using a Sterile Needle and Syringe to Inject Heroin
(No risk)
If the needle and works are sterile, there is no way the virus could be spread.

Cleaning Dirty Works with Chlorine Bleach, Then Using Them to Inject Heroin (No risk)
The 2+2 method kills HIV and cleans out the needle and syringe.

Interviewing Someone Who Has Shot Drugs I.V.
(No risk)
You cannot get HIV from talking to someone.

Sharing a Bath Towel and Wash Cloth (No risk)
HIV cannot live on objects like towels and washcloths.

Spilling a Urine Sample on Your Knee (No risk)
Urine does not contain HIV unless it has visible blood in it.

Sharing a Toilet (No risk)

Two Uninfected People Having Intercourse without a Condom (No risk)
If neither partner has been infected with HIV, unprotected intercourse will not transmit the virus.

Giving a Massage (No risk)
You cannot get HIV through touch.

Donating Blood (No risk)
Sterile hypodermic equipment is consistently used to draw donated blood in the United States.

Watching Partner Masturbate (No risk)

Giving Someone a Ride to the Doctor's Office (No risk)

Sharing a Razor (Some risk—low)
If cuts are made while shaving on someone who is HIV positive and another person immediately afterward uses the same razor, the infected blood could enter any cuts on the second person and transmit the virus.

Having a Kidney Transplant (Some risk—low)
People who donate organs for transplants are tested for HIV so this kind of transmission is very unlikely.

Delivering a Baby (Some risk—low)
If the mother is infected with HIV, and the person delivering the baby does not wear protective gloves and gear, there is a possibility that HIV could be transmitted.

Oral-Anal Sex ("Rimming" Or Kissing the Anus) Using a Latex Barrier (Some risk—low)
It is extremely unlikely that the latex barrier would tear. If it did, however, and if the anus and mouth both had cuts in them, it is conceivable that HIV could be transmitted.

Oral Sex on a Woman without a Latex Barrier
(Some risk—moderate to high)
HIV in vaginal secretions or menstrual blood could enter the bloodstream through small cuts on the lips. HIV could also pass through the mucous membrane lining the mouth and infect the individual whether or not cuts, sores or abrasions are present.

Oral Sex on a Woman Using a Latex Barrier
(Some risk—low)
If the latex barrier tore or was displaced, then there is a possibility that HIV could be transmitted.

Oral Sex on a Man Using a Latex Condom
(Some risk—low)
If the man ejaculates in his partner's mouth, and if the barrier breaks, then there is a possibility that HIV could be transmitted.

Sharing a Syringe to Inject Insulin
(Some risk—high)
Hypodermic equipment used for any injections, subcutaneous or intravenous, may contain blood and should not be shared.

Sharing "Works" to Inject Heroin I.V.
(Some risk—high)
"Works," hypodermic equipment including needles and syringes, should never be shared. If they are shared, they should be cleaned using bleach and water (as in the 2+2 method).

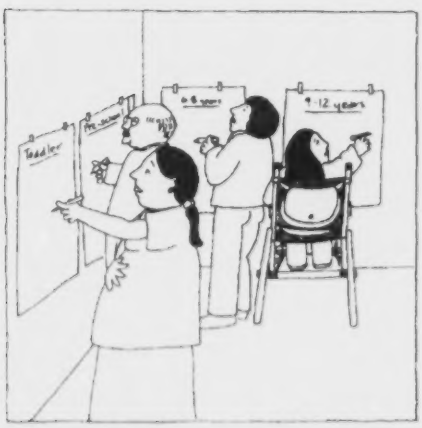
Sharing a Syringe to Inject Steroids
(Some risk—high)
The syringe should be cleaned after use and never shared.

Using Semen for Artificial Insemination
(Some risk—low)
Several women became infected after being artificially inseminated with semen containing HIV. Sperm banks now test semen donors for HIV.

Being Heterosexual/Homosexual/Gay/Lesbian/etc.
(No risk)
It is not who a person is, but what a person does, that leads to HIV infection.

Brainstorm exercise: What do kids need to know about AIDS?

Introduce the exercise by stating, "A main goal of the workshop is for participants to teach young people about AIDS. The risks for HIV infection and the information that kids need to know are different for different age groups, so we are going to outline this information by age groups."



Instructions

Ask participants to use a magic marker and to walk around and write on each sheet how kids are at risk for the infection at ages indicated and what they need to know to prevent HIV infection at those ages.

Allow 10 to 15 minutes. Ask participants to not discuss their responses until later.

After everyone has had a chance to write on the sheets, reconvene the group. Explain that as a group you will all identify how young people are at risk for HIV infection and what they need to know at various ages to prevent infection.

When beginning each sheet, ask the group to summarize (brainstorm) the major developmental characteristics of the age group. Read off the list and invite additions and deletions. Fill in any key information that participants do not provide. (See the pamphlet, "How to Talk to Your Children about AIDS," and the Age Group Charts following this exercise and in the *Resource Manual* for details of age group characteristics and summaries of what kids need to know.)

Move on to the second half of the sheet and review items that participants listed under "What do kids need to know?" Start by saying, "HIV prevention means knowing more than just the facts. It includes the three elements: knowledge, skills, and feelings. Knowledge is basic information and facts. Skills are what you know how to do. Feelings influence what you do and how you learn. HIV prevention education for a young child begins in subtle ways and continues until we provide very specific transmission and prevention information by the age of puberty."

When assisting the group with lists they have made, clarify and add items as appropriate. Keep discussion brief since you could easily spend another hour on it. Then move on to the next sheet. Review all the sheets in the same way.

Conclude by summarizing the overall points and comments made by the group and compliment them on how much they already know. Ask for feedback on the activity. For example, ask, "Did anything from the lists surprise you or give you new ideas?" Remind the group that the key information on age groups needs is in the pamphlet, "How to Talk to Your Children about AIDS," and in the *Resource Manual*. It is also summarized in the Age Group Charts.

Preparation before session

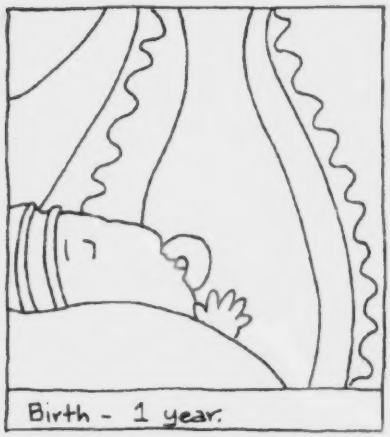
Prepare six large newsprint sheets to place on the walls or table tops. At the top of each sheet write, "How are kids at risk for HIV infection? Ages." Include the following age groups: Infant-3 years, 4-6 years, 7-10 years, 11-13 years, 14-18 years. In the middle of the sheet write, "What do kids need to know?" Tape the sheets to a flat surface (wall or table—not on the floor, if possible).

Age Group Charts

While each child is unique, children in a particular age group share many growth and development characteristics. Children face different potential risks for HIV infection at different ages. The following charts outline some ways adults can help children of various ages to keep healthy and prevent HIV transmission.

Infants

(Birth to one year)



Growth and development of infants

A baby's first year is a time of rapid growth and change. A baby discovers and explores its own body and its immediate world. Newborn babies can move their arms and legs around in the air, but they can't hold up their heads or sit up or stand up—gravity is too much for them. Babies develop their sense of balance and become stronger as the months go by. They become able to hold up their heads, sit up, creep, crawl, and stand. During the first year, the baby develops a sense of trust that its mother, father, or primary caregiver will meet its needs for food, comfort, dryness, cuddling. Infants experiment with conversational sounds and may even say a few words by the end of the first year. They delight in simple play.

How infants may be at risk for HIV infection

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Most babies with HIV became infected this way.

A baby may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

A few babies worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

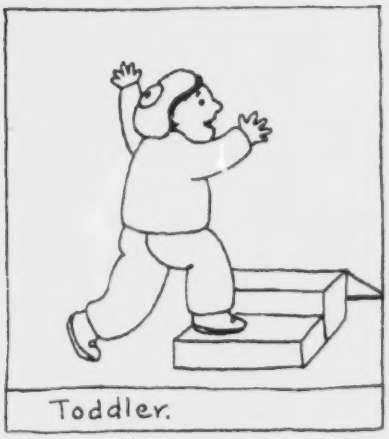
Simple things adults can do to promote infants' health

Infants are dependent upon adults. Adults anticipate and respond to a baby's basic needs for food, comfort, dry diapers, cuddling. This helps the baby to grow and to stay healthy. It also helps the baby to develop a sense of trust. Adults are responsible for keeping the environment safe for babies. Falls, drowning, and suffocation are big risks for babies and can usually be prevented by simple "childproofing" measures. Adults can encourage a baby's discovery of its immediate world. Mobiles, bright forms, faces of loved ones, peek-a-boo games are full of visual discoveries for a baby. Babies discover their own bodies while bathing, waving their arms and legs in the air and tasting their fingers and toes. Normal babies experience different growth patterns and behaviors—each baby is a unique individual. Even with babies, adults can use the correct terms and talk about all body parts. This will help to build a foundation for teaching about sexuality and health later. Adults need to understand that erections are normal for baby boys and that discovery of the genitals is a natural part of learning about and exploring the body.

HIV/AIDS and Children: Age Group Charts
Parent AIDS Education Project
Human Service Studies
Cornell Cooperative Extension

Toddlers

(one to three years)



Growth and development of toddlers

Toddlers are always in motion. They learn by taste, touch and sight. Toddlers may have wide and sudden mood swings. They develop increasing mobility first standing and walking, then running, jumping, climbing stairs. They move quickly and do things on impulse.

Toddlers use one word, then multiword statements. They build a sense of grammar and a big 900-word vocabulary by the age of three (including "me," "mine," and "no"). Desire for exploration and independence appears. Toddlers show interest in using things such as plates, spoons, toilets.

They play beside, not with, peers. Toddlers like rituals, such as the same food in the same spot on the same dish.

Toddlers show interest in the differences between male and female bodies and express the interest by doing things such as following men to the bathroom and touching women's breasts.

How toddlers may be at risk for HIV

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Most toddlers with HIV became infected this way.

A toddler may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

A few toddlers worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

Toddlers are often victims of sexual abuse, which can result in HIV transmission.

Simple things adults can do to promote toddlers' health

Toddlers are dependent on adults. Adults need to provide toddlers with a safe, supportive environment for growth. If you have a toddler in your life, here are some ways you can promote their health and safety now and build a foundation for their future health.

- Recognize the toddler's process of learning by imitation, play, taste, touch, exploration.
- Teach toddlers simple self-care, health and safety skills (dressing, brushing own teeth, resting if tired).
- Teach toddlers that pills are not candy, but always keep medicines in childproof bottles.
- Teach toddlers correct names for all body parts.
- Answer the toddler's questions about sex or AIDS simply and concretely. The toddler won't understand abstract details about AIDS or adult sexual behaviors.
- Support the toddler's sense of competence in exploring the immediate world, and provide a safe, reliable point of return.
- Use "do's" instead of "don'ts" when you want to change a toddler's behavior (for example, try saying "Keep your applesauce in your bowl, Tommy" rather than "Stop putting that applesauce on the cat right this minute, Tommy!").
- Begin to teach toddlers about privacy—that some activities such as bathing, using the toilet, or touching own genitals are private, and that adults sometimes need private time.
- Toddlers are especially vulnerable to ear and respiratory infections and to accidents.

Preschoolers

(Four to five years)

The preschooler's increasing competence means expanding horizons to explore. Preschoolers spend hours in imitative play (such as playing house). Lack of full coordination may lead four-year-olds to talk too loud or squeeze the cat too hard. Five-year-olds probably can "fine tune" their behavior to adult tastes, accept simple responsibilities, take care of many of their daily needs such as dressing (but wait a while before expecting the child to tie shoelaces). Preschoolers are active learners and gain knowledge by doing, not by verbal explanations. They start to identify with adults rather than simply relying on adults.

How preschoolers may be at risk for HIV

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Because of improved care, these babies are living longer, healthier lives.

A preschooler may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

A few children worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

Preschoolers are often victims of sexual abuse, which can result in HIV transmission.

Simple things adults can do to promote preschoolers' health

- Support the preschooler's basic self-care skills.
- Teach preschoolers basic "street safety"—how to cross the street, never to talk to or go with strangers, own name and address and phone number.
- Teach preschoolers never to take drugs or medicines without your approval (and don't give children alcohol or any other "recreational" drug).
- Keep the home environment childproof by keeping objects such as knives and household chemicals out of reach.
- Help preschoolers to continue learning social limits (for example, being touched by adults in sexual or painful ways is something to refuse and report to another, trusted adult).
- Answer questions about AIDS and sex directly, simply, and concretely.
- Coloring books or drawing pictures may be useful in helping preschoolers to understand basic information about AIDS and other topics.
- Use concrete situations such as a cold or a cut finger to explain how germs cause sickness.
- Support the child's vocabulary-building—a five-year-old probably knows about 2000 words!
- Recognize that "playing doctor" is normal as preschoolers explore their own bodies and become curious about friends' bodies.
- Keep offering comfort, love, and a safe, accepting place to be.

Young school-aged children

(Six to eight years)

Growth and development of young school-aged children

Children of this age experience slower growth and change than younger and older children.

They begin to think about issues such as life, death, sickness, religion, and sexual relationships. They probably have heard about AIDS. The early-school-aged child may have projects or near-obsessive hobbies. They may see things as absolutely right or absolutely wrong. The child may become a commuter between home and school daily. At this age, the child becomes very interested in taking part in "adult" projects (cooking, building, sports).

The school-aged child develops a sense of mastery over more and more components of culture and society.

How six-to-eight-year-olds may be at risk for HIV

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Because of improved care, these babies are living longer, healthier lives.

A young child may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

A few children worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

Young children are often victims of sexual abuse, which can result in HIV transmission.

School-aged children could risk HIV infection during play that involves sharing needles or other implements (such as becoming blood brothers).

School-aged children sometimes use injectable drugs and could risk HIV infection by sharing needles and syringes. Diabetic kids need to learn never to share needles and syringes and always to dispose of used injection equipment properly.

Simple thing adults can do to promote kids' health

Answer the child's questions about AIDS and emphasize that people don't get AIDS as a punishment for being bad. The child may express fears about AIDS and need reassurance.

- Support the child's sense of productivity by encouraging and praising activities, projects, school work, sharing in adult tasks.
- Support the child's positive sense of sexuality, privacy needs, physical competence.
- Encourage the child to refuse and report abuse or sexual abuse
- Encourage the child to refuse alcohol and non-medicinal drugs, whether offered at school, at home, or on the streets.
- Build the foundation of knowledge the child needs for puberty. Teach the child basic facts about human reproduction and sexuality. The child's curiosity about intimate objects such as condoms and sanitary napkins may be a good starting point for talks.
- Encourage the child's school to provide accurate AIDS awareness education.

Preteens

(Nine to twelve years)

Growth and development of preteens

This age brings another period of rapid physical growth and change. This leads to strong concern with bodies, appearance, being "normal," as well as intense curiosity about sex. In some children of this age, hormones leading to puberty are already at work. The development of secondary sexual characteristics (such as swelling breasts, growth of pubic and underarm hair, broadening hips, deepening voice) begin as kids stand on the threshold of adolescence. Girls may grow and develop sexually faster than boys. Gay and lesbian people often recognize their sexual orientation at this age and may experience tremendous fear, confusion, and isolation in a heterosexual world. Peer groups become very important. Kids test out values learned at home in the context of their peer groups. Preteens experience powerful social pressures for conformity.

How preteens may be at risk for HIV

A child may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

Children are often victims of sexual abuse, which can result in HIV transmission.

Kids could risk HIV infection during play that involves sharing needles or other implements (such as becoming blood brothers).

Kids sometimes use injectable drugs and could risk HIV infection by sharing needles and syringes. Diabetic kids need to learn never to share needles and syringes and always to dispose of used injection equipment properly.

Sexual intercourse and sexual experimentation may place kids at risk of HIV transmission. Kids may trade sex for food, money, drugs, or shelter.

Simple things adults can do to promote kids' health

Recognize that preteens stand on a threshold—sometimes they are children, sometimes they are adolescents.

- Preteens are curious about sex, need accurate information, and can understand that sexual intercourse has consequences including HIV infection and pregnancy.
- Teach preteens about menstruation, condoms, reproductive health, HIV/STD prevention, sexual decision making.
- Consider teaching your child specifics about condom use and needle safety—it won't push them to try sex or drugs and may help protect their life. Preteens can grasp a full explanation of HIV transmission and prevention.
- Remember that our culture puts special pressures on preteens as their bodies, hormones, and emotions go through tremendous changes. Now is a time to share your values concerning sexual relationships, substance abuse, and other issues in two-way talks with your child. Listen to your child as well as telling them your thoughts.
- Encourage your child to stay free of alcohol and drug use, and act as a positive role model.
- Encourage your child's school to offer accurate AIDS-awareness and HIV-prevention information to each grade level.

Teens

(Thirteen to eighteen)

Growth and development of teenagers

"Adolescence" is derived from a Latin word for "coming to maturity." Puberty begins with a growth spurt and changes in hormonal activity. It ends in sexual and reproductive maturity. Where adolescence ends and adulthood begins depends on social and legal norms as well as individual physical and emotional factors. Adolescents in American society struggle to lay down the foundation for their adult identities. Because our society supports the isolation of teens from adults and the separation of teen culture from adult culture, this struggle for identity is often stormy. It may involve a variety of risk-taking behaviors. Teens may take chances with sex, drugs, high-speed driving, robbery. Sometimes, teens separate themselves from home and family by running away. They may run away to escape physically abusive situations. Adolescence also involves a search for intimacy. Some teens even try to become pregnant so their intimacy needs will be met: "The baby will be one person who really loves me." Teens may experience their first successes with adult roles and tasks (e.g., having a job).

How teens may be at risk for HIV

A teenager may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

Teenagers are often victims of sexual abuse, which can result in HIV transmission.

Kids could risk HIV infection during play that involves sharing needles or other implements (such as becoming blood brothers).

Kids sometimes use injectable drugs and could risk HIV infection by sharing needles and syringes. Diabetic kids need to learn never to share needles and syringes and always to dispose of used injection equipment properly.

Sexual intercourse and sexual experimentation may place kids at risk of HIV transmission. Kids may trade sex for food, money, drugs, or shelter.

Simple things adults can do to promote teens' health

- Contrary to the popular fear, teens do not stop talking or listening to adults. Giving lectures, however, rarely works with teens.
- Remember to really listen to your teenager; often adults do only one fifth of the talking in an effective conversation with a teenager.
- Try to break down the isolation of teens from adults by "mentoring" teens—teaching them skills, sharing your values and thoughts, asking about their own values and thoughts.
- Teach teens complete and accurate information about sexuality, HIV transmission and prevention, HIV-safe sexual behaviors. Teens are able to learn and understand the wide range of HIV/AIDS information available to adults.
- Encourage schools to provide complete and accurate HIV/AIDS education programs. Accompany teens to panel discussions that include young people with HIV/AIDS.
- Recognize the turmoil teens in our society confront as they build their identities. Remind them frequently of their strengths and abilities. Catch teens doing things right more often than you criticize them for doing something wrong.
- Support teens in recognizing and confronting sexual abuse or exploitation.
- Encourage teens to stay free of substance abuse.
- And remember to tell teens as well as young children that you love them.

Round-robin: One strength I have is . . .

Next, using a new sheet for recording, ask members of the group to go around the circle and name one strength they have in relation to teaching kids about AIDS. If people are not responding, prompt the group by naming one simple strength you have.

Challenge: Tell your child . . .

Announce that the group will meet again next week (give time, location, and a number to call if anyone wants to talk about something before that session). Ask if there are any pressing questions that need to be discussed right now. Say that you now have a challenge for everyone in the group. Show the sheet of newsprint with the Challenge on it. Ask participants to tell their child (or children) that they are "taking a class about AIDS" and learning lots of things. Then they should ask their children what they have learned about AIDS and what questions they still have. Tell the group that next week participants will be able to talk with one another about these conversations and learn more about how to teach their kids about AIDS.

Evaluation

Ask participants to say what was useful to them about this session, what could have been better, and what they hope will be included next time. Write their comments on newsprint.

Thank participants. Congratulate them on their knowledge and skills. Tell them you look forward to seeing them again next time.

Risks and Changes

Introduction to Session Two

This second session concentrates on risk reduction. The session begins with feedback on the Challenge from the first session in which parents were instructed, "Tell your child that you are taking a class on AIDS." Sufficient time for reporting the participants' experiences, feelings, and children's reactions is included at the beginning of this session.

After reporting on the Challenge, the material presented in this segment examines the specific risks of HIV infection that young people face. Exercises are used that allow participants to practice answers to information-seeking questions from young people. These exercises give adults the opportunity to review what they know, to give accurate answers, and to practice using frank, correct sexual terms or drug-related language.

The session then moves from the relatively safe information-giving process to examining how people respond to risks and how they might respond to the need for change in their lives. The group will participate in listing what kinds of factors support behavior change.

The group then learns about and practices specific risk-reduction skills, including effective condom use and needle safety.

The Challenge presented at the end of the session provides participants with the opportunity to relate concepts about risk, risk reduction, and change to their own lives by adding to the AIDS Lifeline developed in the first session. The major point in this session is that we all may be at risk and now is the time to do a risk assessment. At the end of the session, the participants will be left with the challenge to do a personal and family risk assessment. This is a personal challenge that will require private time to process. The next session will start with a discussion of this Challenge.

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Session Two Preparation

Meet with your partner to review the curriculum and to clarify who is responsible for what tasks.

Arrive at the meeting place 30 minutes before scheduled start of meeting to set up room and to greet people as they arrive.

Bring along the following materials:

For each participant
name tags
condom-use illustration
needle-safety illustration
two or three condoms

For workshop leader
agenda written on newsprint
blank newsprint
cards with Carousel questions on them
newsprint with the Challenge written on it
refreshments
masking tape
pencils and blank paper
box of nonlubricated condoms
spermicide with nonoxynol-9
water-based lubricant
needle-cleaning kit
syringe *(without needle)*

Set up chairs in a circle. Hang up agenda in front of Challenge sheet. Set up refreshments and place for making name tags.

Assumptions of the session

Session Two assumes that effective AIDS education must at some point hit home with the twin realizations that risk behavior is a personal issue and that behavioral changes may be necessary in one's own family. A parent who has absorbed these messages will approach AIDS education with more urgency and directness.

A second assumption is that parents need time and safety to move from the informational learning stage to the stage of promoting behavioral change.

A third assumption is that parents already have models in their own lives of how to deal with the risk of making changes.

Resources for the session

Review Chapter 1 of the *Resource Manual,* "What is AIDS?" Read Chapter 3, "Risk and Change," carefully, looking for models of how HIV risk assessment and risk reduction might happen. Skim Chapter 2, "How to Talk to Kids about AIDS."

Session Two objectives

1. Participants will become more aware of how young people may be at risk for AIDS/HIV.
2. Participants will become more comfortable discussing sensitive topics, such as sexuality and drug use, with young people.
3. Participants will identify the components of risk-taking behavior.
4. Participants will identify aspects of situations that support risk-reducing choices.
5. Participants will identify risk taking in their own lives.
6. Participants will become aware of how they made changes in their own lives.
7. Participants will learn and practice specific HIV risk-reduction skills.
8. Participants will begin a personal and family risk-assessment process.

Session Two exercise objectives

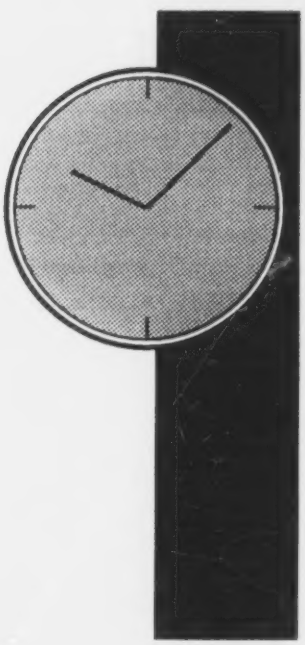
Triads - Report on the Challenge, "Tell your child . . ." Provides a supportive environment to discuss participants' first attempts to use skills and information learned during the first workshop. Provides a bridge to the second session.

Carousel - Participants will become more comfortable discussing sensitive topics such as sexuality and drug use with young people. Provides a review of risk-assessment and risk-reduction information. Gives practice in talking with young people, providing them with accurate information in a manner they understand and using frank language.

"I took a risk when . . ." - Participants will identify the components of risk-taking behavior. Provides a safe environment in which to examine risk in one's own life. Participants will identify aspects of situations that support risk-reducing choices.

Safety Skills - Exploration and discussion of correct condom use, safer sex, and needle safety introduces participants to specific HIV risk-reduction skills.

Personal Risk Assessment - Encourages participants to let HIV information hit home, to personalize the presence of risks, and to build confidence in their ability to make changes in their lives and behaviors.



Agenda for Session Two

Welcome	
Triads: Report on Challenge experiences	*15 minutes*
Review of Session Two objectives and agenda	*5 minutes*
Exercises: Carousel	*30 minutes*
Exercises: "I took a risk when . . ."	*20 minutes*
Workshop: Safety Skills	*40 minutes*
Challenge for next week	*5 minutes*
Evaluation	*5 minutes*
Total time for session:	*2 hours*

Session Two activities: Instructions for facilitators

Welcome

Greet participants as they arrive. If you're using name tags, give one to each participant.

At the scheduled beginning time, **welcome people back:** "This is the second in a series of three classes. In the first class we discussed key facts about AIDS and HIV. This week, we'll talk about risks people take and ways we can help young people to take fewer risks with HIV infection. Next week, we'll work even more on ways to teach children what they need to learn about AIDS, HIV, and keeping safe."

Point out where the refreshments and rest rooms are. Tell people how long child care will continue.

Review the ground rules of the group (confidentiality, listening, supporting).

Ask participants if there is anything from last week's session that they feel confused about and respond to their questions.

Ask participants to break into groups of three to talk about the Challenge from last week. How did the conversations with kids about AIDS go? What kinds of questions did their kids have about AIDS? After ten minutes, ask participants to rejoin the larger group.

Review the Session Two agenda and objectives: "The focus of today's session is on reducing the risk of getting HIV infection. We will practice answering some questions that children might ask and we will talk about risk in our own lives and families. We will also practice some very basic skills that will help us to avoid HIV infection. During this session, try to think about what kinds of risks you and your own family have faced and the kinds of changes you might want to make to reduce health risks in the future."

Exercise: Carousel*

Introduce the Carousel exercise as a way to practice working with young people to reduce risks. Select the question list that best suits the age group(s) of your participants' children.

Ask participants to count off. Have the people with even numbers stand in a circle facing outward. Have the people with odd numbers stand facing them. Give cards with questions on them to people in the outside circle.

Tell participants to ask the question of the person standing opposite them. Remind the participants to use correct, explicit language and to avoid euphemisms in their responses.

Allow three minutes for the people on the inside circle to respond, then allow two minutes for the people on the outside circle to give feedback on the responses—how they felt and was the answer effective. Then, have the people on the outside circle move one person to the right and ask their questions again. Again, allow three minutes for the response, and a couple minutes for feedback. (If there is time, you may repeat this.) Then, collect the question cards from the people with odd numbers, shuffle the cards, and give them to the people with even numbers. Have them ask their questions, receive responses, and give feedback at least twice.

Then call the group back together to review the experience. Make a list of what responses were helpful and unhelpful. Make a list of what elements were difficult to answer and what elements people felt they responded to effectively. End after listing what people felt they did well.

*Adapted from "Working with Uncertainty: A Handbook for Those Involved in Training on HIV and AIDS," by Hilary Dixon and Peter Gordon, Family Planning Association Education Unit, 1987.

Carousel question mix 1

(Young Children)

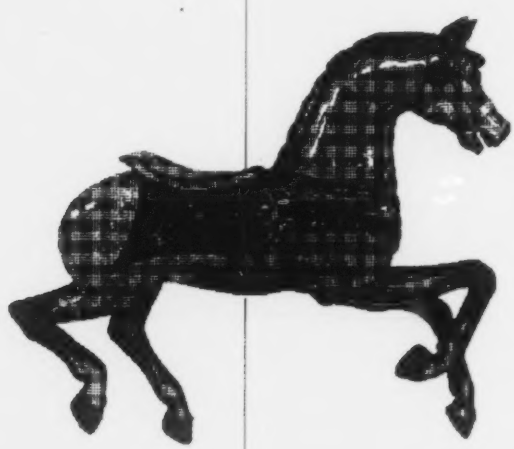
1. Am I going to die of AIDS?
2. What is a germ?
3. How do people get AIDS?
4. What does "sex" mean?
5. How do children get AIDS? What happens to them then?
6. When I go to the doctor, won't I get AIDS from the needles?

(Teeens and Preteens Who Aren't Sexually Active)

1. Why shouldn't I use drugs? You drink wine and beer!
2. What does safe sex mean?
3. Did you wait until you were married?
4. How long does it take for someone to get AIDS if they got the virus when they were my age?

(Sexually Active Teenagers)

1. If I carry condoms, won't my boyfriend think that I'm sleeping with other boys?
2. If the condom breaks, what should we do?
3. I don't know exactly how to start a conversation about safe sex. What should I say exactly?
4. Can kids go anonymously to a test center if they think they could have HIV?



Carousel question mix 2

(Young Children)

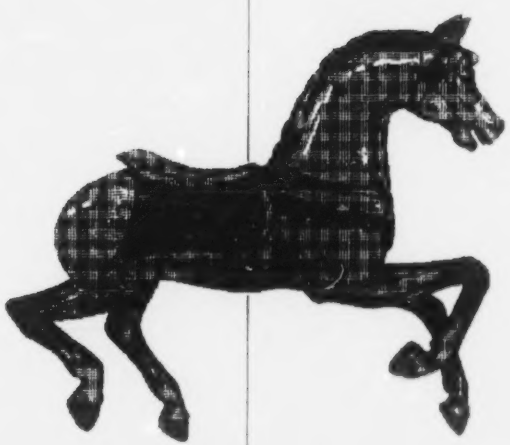
1. Can my dog get AIDS when he marries other dogs?
2. How can people make sure that they don't get AIDS?
3. If you go out with him, will you get AIDS?
4. What does "gay" mean?
5. What are these (condoms)? I found them in the drawer in Suzie's room (23-year-old cousin).

(Teens and Preteens Who Aren't Sexually Active)

1. Is it okay not to have sex? It sounds pretty scary!
2. What is a condom?
3. Why don't they just lock up everybody who has AIDS?
4. How does someone know if they are gay?

(Sexually Active Teenagers)

1. Is it okay not to have sex at all? I don't enjoy it very much.
2. My friends aren't getting AIDS and they've been having sex for two or three years. Why should I worry about it?
3. If someone thinks they are infected because of what they already did, what should they do now?
4. If someone is pregnant, they could have gotten HIV, right?
5. A person is straight if they have sex with someone of the opposite sex, right? It doesn't matter if they have sort of a crush on their best friend, does it?



Carousel question mix 3

(Young Children)

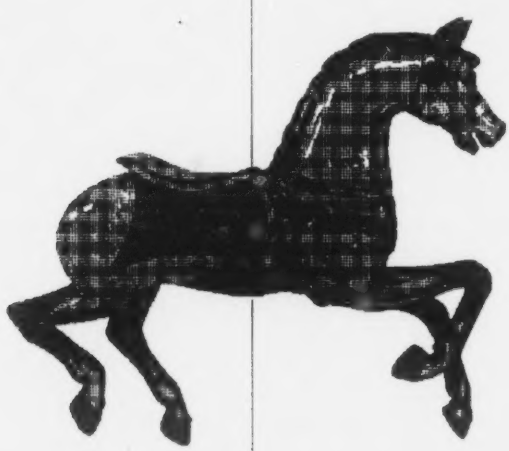
1. Jack is always putting girl's clothes on from the dress-up box. Will he be gay?
2. Why can't they make people with AIDS get better?
3. How can you catch a cold from someone who sneezes on you, but you can't catch AIDS. Aren't they both from viruses?
4. If Daddy has AIDS, how can we visit him? Won't we get sick?
5. Why do people who do drugs get AIDS?
6. Why does blood stay under my skin?

(Teens and Preteens Who Aren't Sexually Active)

1. How come men get AIDS and women only carry the virus?
2. So it's alright to have sexual intercourse as long as you use a condom?
3. How do people know when they are gay?
4. Can I go to that party at Julie's house?

(Sexually Active Teenagers)

1. Can you get infected the first time you sleep with someone?
2. Is there anything you can use instead of a condom, in an emergency?
3. If I go to a clinic, will they ask me a lot of questions about what I do with my boyfriend?
4. If I don't do the things that gay people do, then I won't get infected, right?



Exercise: I took a risk when. . .

Introduce the "I took a risk when" exercise.

Ask each participant to take out a piece of paper and pen for the exercise or pass out these materials.

Say: "Each of us has probably risked our own health at some point. Looking at ways we've taken health risks may help us to understand how young people may come to risk their health. It may help us to be more effective at teaching young people about ways they can stop risking HIV infection."

Pause.

"Think about the questions I ask. This is private, and you won't have to tell anyone details of risks you've taken, unless you choose to."

"Think about a time you did something that you knew was risky to your own health or the health of another person."

Pause.

What information did you have about the risks involved at that time?

What control did you have over the situation? In what ways did you feel you didn't have control?

What did you need to make the change from a health-risk behavior to a healthy behavior?

"Now think about a health risk that you are taking right now. It should be something that you would like to change or something that is recommended that you change to improve or protect your good health. Maybe you are thinking about a different risk than you focused on before or maybe it is the same risk."

Pause.

How difficult is it for you to make this change in your life: Write down "Easy," "Hard," or "Extremely Difficult."

What are the things that prevent you from making this change right now, right away, today?

Write these things down in a list. You do not have to use whole sentences, just key words that will help you remember each item.

What would help or motivate you to make this change right now? Write these down in a list next to the first list.

When everyone is through writing, begin a discussion about the answers. Using a large piece of newsprint, make two columns. Label one, *Prevents Change,* and the other, *Supports Change.* Solicit items from the group for each column.

Many of the items the participants will offer will appear on the lists of others, so ask, "How many people had '_____' on their lists?" Also, some items will appear in both columns; for example, "other people I know are doing it" might be in the *Prevent* column or in the *Support* column. Point this out to the group.

Relate the lists to HIV infection prevention: People need information, support, and resources to make key changes in their lives. Change itself almost always feels risky. There is a sense of losing something and moving toward a future that is somewhat unknown. As you discuss change, bring out these points with the group.

End the discussion by suggesting, "Young people are experiencing these same problems in making changes. To adopt HIV prevention behaviors they will need information, support, resources."

Workshop: Safety Skills

Introduce the mini-workshop on safety skills by providing a brief review of material already covered. The Myths and Facts about AIDS discussion during the first meeting covered a variety of ways that people can prevent HIV infection. For example, sexual transmission of HIV can be reduced or eliminated by

1) abstinence from vaginal, anal, and oral intercourse,
2) practice of monogamy by uninfected partners,
3) using latex condoms correctly during intercourse, and
4) practicing nonpenetrative sex.

Injection equipment will not transmit HIV if people

1) use only sterile needles and works,
2) never share hypodermic equipment with anyone, or
3) always clean shared hypodermic equipment with bleach and water before using it.

People determine what form of prevention they wish to practice based on their individual and community beliefs, values, and norms. People may choose to abstain completely from activities that can transmit HIV, or they may choose to reduce the likelihood of HIV transmission by practicing safety skills. Sometimes, very specific risk-reduction norms are followed by large numbers of people. For example, the universal precautions that health care workers are required by law to practice involve a number of specific safety skills: wearing latex gloves to keep from touching blood and other possibly infectious body fluids, disposing of used needles and sharp equipment in hard plastic containers, not recapping needles, and so forth. Sometimes prevention practices involve very personal decisions. Discussions about abstinence, condom use, needle cleaning, and other aspects of prevention education may involve strong emotions. The safety skills workshop teaches correct condom use, needle cleaning, and other specific safety precautions. The discussions might cover personal thoughts and feelings on condom use, needle cleaning, needle exchange and drug rehabilitation programs, safer sex, abstinence, and a wide variety of topics. Each participant will gain specific information on how latex barriers block the transmission of HIV and how the 2+2 needle-cleaning process reduces infections spread by sharing needles and works. Each participant could be in a position to teach or tell someone else about these methods—and sometimes safety skills are lifesaving skills. Demonstrating or talking about safety skills may be a way of starting a conversation about prevention that can cover a wide range of ways people can reduce or eliminate their risk for HIV infection.

Safer Sex *(optional exercise):* Safer sex means that semen, vaginal secretions, menstrual blood, and blood from one partner do not contact the mucous membranes or get inside the body of the other partner. Remind people about the card game exercise on HIV transmission. Pass out 3 x 5 cards and ask everyone to write down one *safe* sexual activity on a card. Collect the cards, read them aloud, and discuss how sexually active young people might view safer sexual practices. How do young people view abstinence? Condom use?

Condom Demonstration: Pass out copies of the condom-use illustration and distribute two or three nonlubricated latex condoms to each person in the group. Demonstrate and explain:

- opening the package
- leaving some space at the tip of the condom for ejaculate (or point out the receptacle tip)
- squeezing air out of the tip of the condom to reduce the chance of breakage
- unrolling the condom over your fingers to show that it only unrolls one way; if the condom doesn't unroll, it's upside down
- removing the condom from your fingers
- tying off the end of the condom so it can't be reused
- disposing of the condom

Explain that uncircumcised men will need to retract the foreskin of the penis when putting on condoms.

Ask participants to take turns putting a condom on another participant's fingers. Answer any questions. To demonstrate that condoms do not block sensation, ask participants to pretend they are blowing out birthday candles and to blow on the fingers covered by the condom. Can they feel their breath? Ask participants to place their hands around the fingers that are covered by a condom. Can they feel whether hands and fingers are warm or cold?

Next, explain the correct use of water-based lubricants and spermicides. It is important to use lubricants during vaginal and anal intercourse. They help to keep the condom from breaking and also reduce cuts and tears to the mucous membranes. Explain that only water-based lubricants (such as K-Y Jelly) should be used. Oil-based lubricants (such as Vaseline or hand lotion) damage latex condoms. Nonoxynol-9, a spermicide that kills HIV, is contained in some lubricants. A small dab of this spermicide, or another water-based lubricant, can be placed in the tip of the condom. Lubricants containing Nonoxynol-9 can be used on the outside of the condom during vaginal intercourse, if the woman doesn't experience any irritation from the spermicide. If she experiences irritation, plain, nonspermicidal lubricants are best. Plain lubricants should be used on the outside of the condom during anal intercourse and during vaginal intercourse during pregnancy. No lubricants are needed on the outside of the condom during oral intercourse.

Open a new condom and demonstrate placing a dab of spermicidal lubricant in the tip of it before unrolling it. Next demonstrate placing water-based lubricant on the outside of the condom. Point out that prelubricated condoms, some containing Nonoxynol-9 and some containing plain water-based lubricants, are also available.

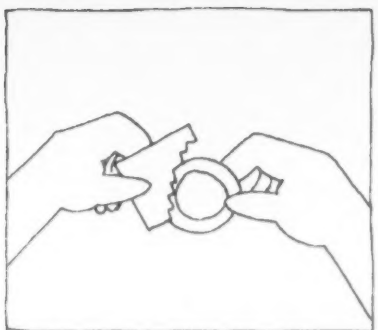
To demonstrate the effect of oil-based lubricants, conduct a small experiment. Blow up two nonlubricated condoms and tie them shut. Put Vaseline on one and K-Y Jelly on the other. Continue the workshop, then come back to them. The condom with Vaseline will break much more easily than the one covered with a water-based lubricant.

Try to have a wide assortment of condoms for your demonstration and discuss places that sell or give away condoms in the local community. While conducting the condom demonstration, it's important to acknowledge directly that people may feel uncomfortable touching or talking about condoms. Encourage open sharing of thoughts and feelings. Especially encourage men in the group to share their thoughts about buying and carrying condoms as youths and to imagine how they might reduce feelings of embarrassment for their own children. If some members don't want to participate in the demonstration, that is okay.

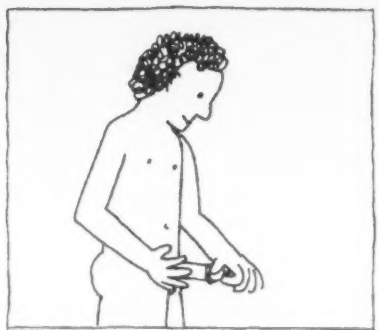
Some groups wish to discuss ways to begin discussions of correct condom usage at home or ways to encourage sexually active young people to use condoms.

Here are some ideas generated by past groups:

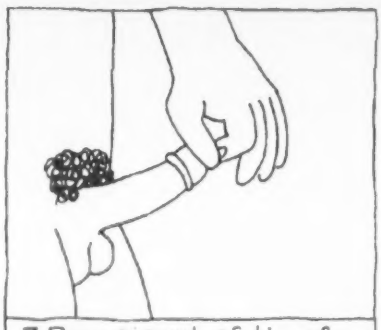
- Let condoms be in plain sight along with other personal care products.
- Give condoms as gifts to sexually active teens.
- Take condoms home from the workshop and use them as conversation starters. Ask a young person to observe and critique a method of teaching about correct condom use.



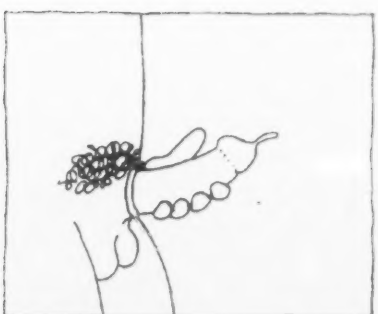
1. Open package carefully.



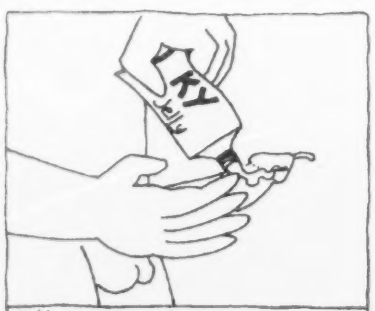
2. Put condom on erect penis.



3. Press air out of tip of condom.

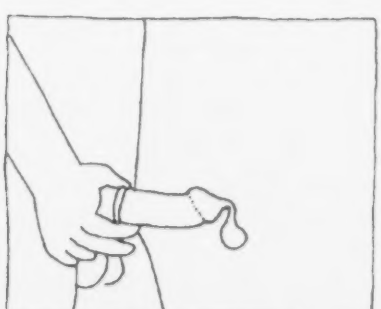


4. Unroll condom and cover whole penis.

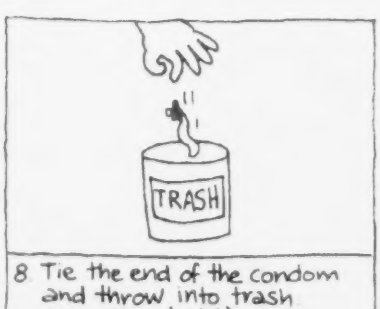


5. Always use water-based lubricant to help keep condom from breaking.

6. Hold onto base of condom during insertion.



7. After sex, hold condom at base and pull out gently before penis gets soft.



8. Tie the end of the condom and throw into trash (not down toilet). Only use a condom once.

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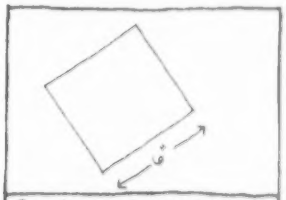
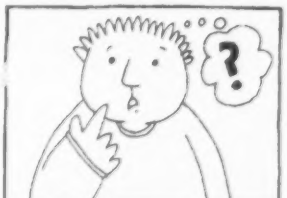
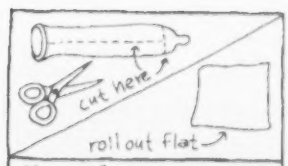
Latex barriers may be used during oral-vaginal or oral-anal sex. They reduce risk of HIV infection because they keep vaginal secretions or blood from entering the mouth.



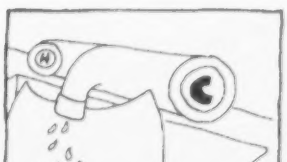
Sometimes, latex dental dams are used as latex barriers. They are flat pieces of latex about six inches square.



Dental dams may be hard to find. They are sold through dental supply houses.



You can "cut down" a non-lubricated latex condom to make a latex dam. Don't use Saran wrap or plastic wrap. Some plastic wraps have pores that will allow viruses to pass through.



Suggestion: A dental dam can be rinsed in cold water before use to wash off the cornstarch powder.

You can use a water-based lubricant on the vulva or anus side of the dam.

Place dam over vulva for oral sex on a woman.

Place dam over anus for oral-anal sex on a woman or a man.

IMPORTANT: Be sure to keep one side to you and one side to your partner. You can make a small "X" on one side. And don't use the same barrier for anal and then vaginal sex.

Use a latex barrier only once, and then throw it away. Don't flush it down the toilet.

So far, there have been no clinical studies to test the effectiveness of dental dams or latex barriers in reducing the risk of HIV transmission.

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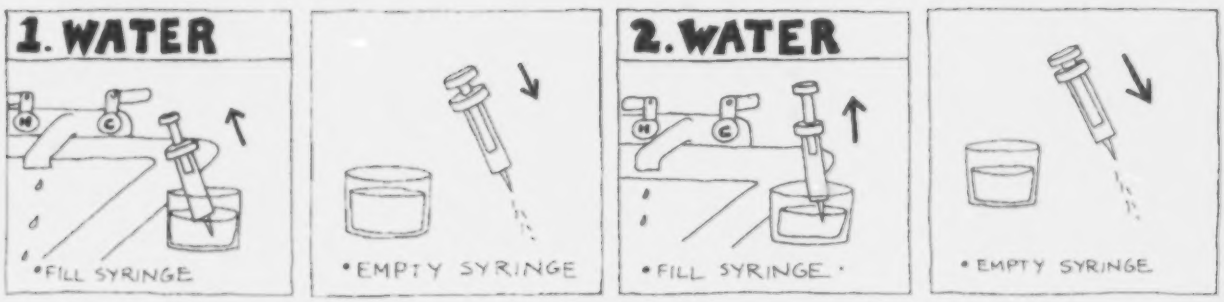
1. BLEACH
BLEACH
• FILL SYRINGE
• EMPTY SYRINGE
2. BLEACH
BLEACH
• FILL SYRINGE
• EMPTY SYRINGE

+


1. WATER
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• EMPTY SYRINGE

=

2+2 method

Dental Dams/Latex Barriers: Dental dams (square pieces of latex developed for use in dentistry) are used as barriers between the mouth and the vulva or the anus during oral sex so that no vaginal secretions, blood, or other body fluids enter into the partner's mouth. HIV has been transmitted through oral/vaginal contact in some cases. Hepatitis A has often been transmitted during "rimming" (oral contact with the anus). Latex barriers can reduce these risks. Review the handout on using latex barriers. Pass around a dental dam. Also, demonstrate cutting a nonlubricated condom open so that it forms a latex rectangle. One or both partners can hold the latex barrier in place during sex.

Female Condom/Intravaginal Pouch: The intravaginal pouch fits inside a woman's vagina during intercourse. It is a latex pouch with a ring holding it in place near the cervix and another ring on the outside of the vulva. It is another effective barrier method for preventing exposure to HIV during intercourse. Pass around an intravaginal pouch so that participants can examine it.

Remind the group that birth control pills and IUDs may actually increase the chances of HIV transmission during vaginal intercourse with an infected man.

Needle Cleaning/2+2 Method: Point out to the group that drug use may sometimes be even more difficult to discuss openly than sexuality. HIV is easily transmitted from person to person when needles and syringes are shared. Waiting lists for drug treatment programs are currently very long, so learning and teaching the 2+2 method of needle cleaning is important.

First, show the group a syringe and teach them the names for different parts of the syringe: the needle, the bore (the hole inside the needle), the barrel with amounts marked on the outside, and the plunger. Also show the group a spoon and a small piece of cotton. Explain that the specific kind of hypodermic equipment, the type of drugs, and the usual way of injecting drugs varies a great deal from person to person and from community to community, so this will be a general description. When a person is going to inject drugs intravenously, they purchase and mix the drugs, sometimes using a metal spoon and a lighter to heat the mixture. The mixture is drawn up into the syringe, sometimes strained through a small piece of cotton. The person locates a vein, puts the needle into the vein, draws back a little bit to make sure that the location is correct (this brings a small amount of blood into the syringe), and then injects the drug. Sometimes, blood is drawn back into the syringe and then reinjected to flush out the last of the drug. If the hypodermic equipment is shared, blood from one user is easily injected into the veins of another user, frequently transmitting HIV.

Next, demonstrate the 2+2 method. Pour chlorine bleach into one cup and clean water into another cup. Draw bleach up into the barrel of the syringe once, then squirt it out; then draw up bleach again and squirt it out. Afterward, draw up water into the barrel and squirt it out twice. Rinse the spoon or cooker in the bleach and then in the water. Throw out the cotton.

Encourage participants to examine the hypodermic equipment, practice cleaning it with bleach and water, and ask questions. Facilitate a brief discussion of participants' thoughts and feelings on injectable drugs and needle cleaning. Participants may wish to discuss actual situations in their communities in which young people may share injection needles. If organizations in the community distribute needle-cleaning kits, pass kits around so that participants can examine them.

After the Safety Skills workshop, tell participants that the group will meet again next week (give time, location, and a phone number for someone they can call if they want to talk about anything before that session). Ask if there are any pressing questions that need to be discussed.

Challenge

Tell people that you now have another Challenge for them. Show the sheet of newsprint with the challenge written on it. Tell the group that one of the most important things about keeping safe from HIV is being realistic about whether we or our families may be at risk. Once we understand any current or future risks for HIV infection, we can make clearer choices about putting our safety skills to work.

Ask the group to use the AIDS Lifeline page they saved from the first session to represent risks they, or people they love, may be taking, and to represent a timeline for making changes so that they will keep safe. Emphasize that this is a very hard challenge and that it will probably involve each of them thinking about it privately. Next week there will be time to talk about it with the group if they choose. Some participants use the questionnaire "Looking at your own risks" (below) as a resource for thinking about this challenge.

Remind the group of the local resource list. This includes phone numbers of places that can give them more information or that could answer questions or just talk with them about their concerns.

Evaluation

Evaluate today's session. Using newsprint, ask participants what was useful to them about this session, what could have been better, and what they hope will be included next time.

Thank participants. Congratulate them on being a good group and tell them you look forward to seeing them again next week.

Personal Questions: Looking at your own risks

This questionnaire is meant for you to answer privately. It may help you assess your risk of having been exposed to HIV. It can't tell you whether you have contracted HIV. Its purpose is to make you aware of any potential risks you may be taking.

You will *not* be asked to hand in this questionnaire. Please answer as many of the questions as honestly as you can. Some program participants have asked for extra questionnaires to share with members of their families.

Each question has a point value shown at the left in parentheses. You will add up the points from your responses to learn your risk score. Remember, a high score does not mean you have contracted HIV. And a low score doesn't guarantee you haven't. You may want to talk to a doctor or health counselor about any concerns you have after doing the questionnaire.

1. In the past twelve years I have had sex with
   - (0) ____ no one
   - (1) ____ one person
   - (2) ____ 2-4 people
   - (3) ____ 5-9 people
   - (6) ____ 10 or more people

2. During the past three years (check up to two answers that most apply to you),
   - (0) ____ I have been celibate (not sexually active).
   - (1) ____ I have been in a steady sexual relationship or marriage that I believe is monogamous.
   - (3) ____ I have been in a sexual relationship in which I have been monogamous but my partner may not have been.
   - (5) ____ I have had multiple sexual relationships with partners pretty well known to me.
   - (10) ____ I have had multiple sexual relationships with partners I don't know well.

3. My sexual activities during the past three years include (check all that apply to you):
   - (5) ____ unprotected (no condom) oral, vaginal or anal intercourse
   - (2) ____ oral, vaginal or anal intercourse using condoms or latex barriers.
   - (0) ____ kissing, massage, masturbation.
   - (0) ____ celibacy (not sexually active).

4. Question for men only: In the past twelve years, I have had unprotected (no condom) anal intercourse with another man.
   - (20) ____ Yes.
   - (0) ____ No.

5. The following best describes my discussions about HIV/AIDS with my present partner or partners during the past three years (check the one that most applies to you today):
   - (25) ____ I know my partner may be at risk for HIV infection. We've discussed that, but we continue to practice unsafe sex.
   - (20) ____ I suspect a partner may be at risk for HIV, but we haven't discussed it.
   - (4) ____ I've discussed HIV/AIDS with my current partner and there are no evident risks, but I haven't looked into the past.
   - (2) ____ I have discussed HIV/AIDS with my current partner and past partners; I am not aware of any risks.
   - (1) ____ I have discussed HIV/AIDS with my current partner and past partners and we have consistently practiced safer sex.
   - (0) ____ I have been celibate (not sexually active).

6. The following best describes my drug use (check any that apply):

   (25) ____ I have shared needles to inject drugs in the past five years.

   (20) ____ I gave up sharing needles to inject drugs five years or more ago.

   (6) ____ My use of alcohol or drugs (crack, cocaine, amyl or butyl nitrite, marijuana, quaaludes, amphetamines, or other substances) sometimes leads me to have sexual encounters I'd like to forget about.

   (0) I have not used recreational drugs.

7. The following best describes my current attitude toward HIV/AIDS (check one):

   (5) ____ Even though I take some risks, I really don't think I could ever get it.

   (3) ____ I believe anyone can get it from sexual intercourse or sharing needles, but I still don't want to think about it or to try to reduce my risk.

   (1) ____ I am trying to learn about risk reduction and discuss the subject with male and female friends.

   (0) ____ I am consistently practicing safe behaviors.

8. I received transfusions of blood or blood products prior to March 1985.

   (5) ____ Yes.

   (0) ____ No.

9. I have experienced a needlestick injury or have been splashed in the eyes or mouth with blood during the course of my work.

   (5) ____ Yes.

   (0) ____ No.

To determine your score, add up the numbers beside each answer checked.

My score is _____

KEY

25 or more: Possibly high risk. Your past or present behaviors may have put you at high risk for HIV infection. Consider making changes that would lower your risk. You may wish to talk to a counselor to learn more about reducing your risk behaviors. You may want to consider getting an HIV antibody test.

15 - 24: Moderate risk. Some of your past or current behaviors may have put you at risk for HIV infection. Consider making changes that could lower your risk. Learn how to avoid HIV infection through a workshop, counselor, or literature.

14 or less: Relatively low risk. You should continue to monitor your risks carefully and make sure your partner understands reducing risk for HIV infection.

Adapted from: Norwood, Chris, *Advice for Life: Women's Guide to AIDS, Risks and Prevention*, Pantheon Books, 1987.

Talking with Kids about AIDS and HIV

Introduction to Session Three

The first activity of this session is a discussion of last week's Challenge (a personal and family risk assessment and risk-reduction plan) in groups of three. The relatively small size of these groups will provide participants with time and safety to share their concerns and plans if they so choose. The individual work of assessing risk and planning change on a personal and family level will increase participants' perception of the need for developing a specific plan for talking with their children.

The skill-building component of this final session focuses on communication. Effective communication strategies are spelled out and explored. Exercises provide participants with practice in using those skills in talking to kids about HIV risk reduction.

Much of Session Three focuses on the development of a specific plan by each participant for talking with their children about AIDS and HIV risk reduction. These plans are shared with members of the group. The completed plans will assist group members with the closure process as the workshop series ends. Additional community activities related to AIDS in which group members can participate will be discussed.

Post-test and evaluation materials are integrated into a general discussion of future plans around AIDS awareness and HIV risk-reduction activities.

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Session Three Preparation

Meet with your partner to review the curriculum and to clarify who is responsible for what tasks.

Arrive at the meeting place 30 minutes before the scheduled start of meeting to set up the room and to greet people as they arrive.

Bring along the following materials:

For each participant
name tags
communication skills handout
strength bombardment sheets
strength affirmation stickers
post-test and evaluation forms
pencils
cards

For workshop leader
agenda written on newsprint
blank newsprint
newsprint with "A- I- D- S- stands for..." written on it
refreshments
masking tape
pencils and blank paper

Set up chairs in a circle. Hang up agenda. Set up refreshments and place for making name tags.

Assumptions of the session

One assumption of this session is that participants will feel enough safety in the group and competency in relation to AIDS information to carry out the personal and family risk assessment and risk-reduction planning spelled out in the Challenge exercise.

Another assumption is that the Challenge process will increase participants' motivation to talk with their children about AIDS and HIV risk reduction.

A further assumption is that parent education about AIDS, already difficult because of the sensitive topics of sexuality and drugs, may be further complicated by the challenges of parent-child communication. Participants must feel enough support from the group and from the facilitator to take on these multiple challenges.

This workshop series poses many risks and challenges to participants, including self-assessment and family assessment regarding risk of HIV infection or participation in unsafe behaviors, challenges to change behaviors, and the possibility of disclosure of personal information to other group members. A final assumption is that learning accomplished in this environment will promote behavioral change more than purely cognitive learning.

Resources for the session

Read carefully Chapter 2, "How to Talk to Kids about AIDS," in the *Resource Manual*. Also read the book, *Does AIDS Hurt?* Review Chapter 1 of the *Resource Manual*, "What is AIDS?" if you feel at all unclear about basic information. Review the general and local resource lists.

Session Three objectives

1. Participants will practice personal and family HIV risk-assessment skills.
2. Participants will experience peer support for their risk-assessment and risk-reduction efforts.
3. Participants will understand that they are able to value and communicate with the young people in their lives consistently, even though they may not consistently approve of what the young people are doing.
4. Participants will practice supporting young people in learning to reduce their risk of HIV infection.
5. Participants will experience the relationship between feeling valued and enhanced self-esteem.
6. Participants will explore adult-child communication techniques that support the child's self-esteem and encourage risk-reducing choices.
7. Participants will develop a specific plan for talking with their children about HIV and AIDS.

Session Three exercise objectives

Challenge discussion - Participants will practice and share personal and family HIV risk-assessment skills. Participants will experience peer support for their risk-assessment and risk-reduction efforts. Bridge between Session Two and Session Three.

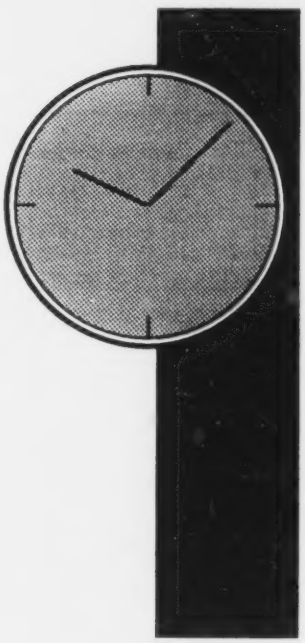
Kids share when . . . - Participants will consider their children's communication style and optimal situations for talking with them about AIDS and HIV.

Strength bombardment - Participants will experience the relationship between feeling valued and enhanced self-esteem.

Triad: Conversations with kids about risks and choices - Participants will practice adult/child communication techniques that support the child's self-esteem and encourage risk-reducing choices. Participants will practice supporting young people in learning to reduce their risk of HIV infection. Participants will understand that they are able to value and communicate with their children consistently, even when they may not consistently understand or approve of what their children are doing.

A-I-D-S stands for . . . key elements of discussing AIDS with kids - Participants will learn word associations that help them remember when and how they can talk with their kids about AIDS.

Plans for talking with kids - Participants will develop a specific plan for talking with their children about AIDS and HIV. Participants will learn alternate plans and approaches by sharing their ideas with one another. Participants will feel encouraged to carry out their plans after leaving the workshop.



Agenda for Session Three

Check-in	*5 minutes*
Discussion of Challenge	*15 minutes*
Communicating positively	*5 minutes*
Brainstorm: Kids share when . . .	*5 minutes*
Exercises: Strength bombardment	*25 minutes*
Roleplay: Risk and choice conversations	*20 minutes*
Brainstorm: A-I-D-S stands for . . .	*5 minutes*
Triads: Plans for talking to kids	*20 minutes*
Round-robin: One good thing about my plan is . . .	*5 minutes*
Post-test	*5 minutes*
Evaluation and "where to from here?"	*10 minutes*
Total time for session:	*2 hours*

Session Three activities: Instructions for facilitators

Greet participants as they arrive. If you're using name tags, give one to each participant (you may not need them by the third week).

At the scheduled beginning time, **welcome people back.**
Say: "This is the last in a series of three classes. The first class talked about key facts on AIDS and HIV. Next we talked about risks people take and ways we can help young people to take fewer risks with HIV infection. This week we'll work even more on ways to teach kids what they need to learn about AIDS, HIV, and keeping safe."

Point out where the refreshments and rest rooms are and tell the group how long child care will continue.

Review the ground rules of the group (confidentiality, listening, supporting).

Ask participants if there is anything from last week's session that they feel confused about and, respond to their questions.

Challenge discussion

Ask participants to break into groups of three to talk about the Challenge from last week. Suggest focus questions:

> **How did it feel to each person to deliberately think about personal or family risks for HIV infection?**
>
> **What Safety Skills did they think might be useful?**
>
> **What timelines did they develop for making changes?**
>
> **What supports do they need to encourage these changes?**

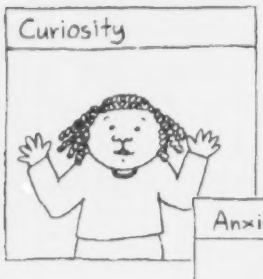
After ten minutes, ask participants to rejoin the larger group.

Review today's agenda and objectives.
Say: "We have been focusing on HIV and risk reduction. Today we are going to focus on our children—how to talk to them and how to help them reduce risk. This will involve reviewing some good communication skills." Go over the handout on communicating positively.

Communicating positively with kids about AIDS and HIV

Kinds of questions*

When children ask questions about AIDS, it is important to understand the meaning behind their questions:



1. **Information-seeking and general curiosity**
   Fairly straight forward questions based on the natural curiosity of children.
   Example: How do people get AIDS?

2. **Anxiety for personal welfare**
   Questions based on anxiety with the intent of finding out if they are at risk themselves.
   Example: Can you get AIDS from kissing?

3. **Anxiety for the welfare of parents, siblings or other relatives, and friends.**
   Questions, sometimes quite direct, based on kids' knowledge about adult behaviors that kids know may be connected to HIV infection.
   Example: Is it okay for my daddy to have sex?

4. **Solution-seeking**
   Based on kids trying to come up with solutions to a fatal disease.
   Example: Can we give somebody with AIDS new blood?

5. **Seeking reactions from adults**
   Based on children's sensitivity to adult feeling about AIDS, these type of questions are asked to see how the adult will handle a difficult or embarrassing question. Answer calmly, factually, in an honest, matter-of-fact style.
   Example: Did you have sex before you got married?

6. **Special psychological needs**
   Intense preoccupation of a child with AIDS or another issue. If excessive concern persists, seek counseling.
   Example: Without any apparent reason your son has been asking questions about AIDS three or four times a day for over a month.

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*Adapted from *Does AIDS Hurt? Educating Young Children about AIDS*, by M. Quackenbush and S. Villarreal, Santa Cruz, CA: ETR Associates, pp. 17–19. 1988/1992.

Guide to answering questions

1. **Try to understand the meaning behind the question.**
   See above.

2. **Answer it now, rather than later.**
   Example: Your child interrupts you while you are watching your favorite television program with a question about AIDS. Answer the question. Don't say, "Not now, I'm busy."

3. **Answer calmly, in matter-of-fact manner.**
   Example: Your child says in an accusatory tone, "You're going to get AIDS if you keep going to all those meetings on sex". You answer concerns calmly and directly by explaining that you can't get AIDS by talking with people or going to meetings. You may want to explain (again) how AIDS is transmitted. You also may address the real problem of attending a lot of meetings lately.

4. **Admit it if you do not know the answer to a question.**
   Example: Your child asks you where HIV came from. You admit that you don't know. You look it up the next day and find out that nobody else knows either.

5. **Find out new facts and get back to the child with an answer later.**
   Example: The next evening you report back to your child that there are lots of ideas about where HIV came from, but none of the ideas has been proven yet.

6. **Answer questions in a way that is appropriate to the age and sophistication level of the child.**
   Example: Your kindergartner asks you "What's AIDS?" You tell him it is a serious disease that some people get. You add that it is a hard disease to get, so he doesn't have to worry about getting AIDS.

7. **Answer questions honestly and concisely.**
   Example: Your child asks you if a family member, Uncle Dan, has AIDS. You say, that Uncle Dan has an infection that leads to AIDS in many people. You can also say that you don't know yet whether Uncle Dan will get AIDS. Right now he is healthy and the doctors are giving him medicine to keep him healthy.

8. **Check to see if the child understands the answer.**
   Ask the child to answer a question for you to check his understanding of the information.
   Example: "Now you can tell me, does Uncle Dan have AIDS?" If the child can tell you the information in her own words, she has probably understood what you said.

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Listening

Above all, listen to your child. The less you talk, the more you may learn. Listen for the meaning behind the questions they ask. You need to understand exactly what young people are concerned about before you can address their questions. Too often young people accuse adults of not listening; too often they are right.

Listening includes watching for nonverbal cues, and asking for clarification when you don't quite understand. It means quieting down that part of our brains that always debates with the person who is speaking. Really listening is one way to show young people that you care.

A-I-D-S

Here is an easy way to remember key elements in talking with young people about AIDS. The letters A-I-D-S can stand for more than Acquired Immune Deficiency Syndrome. When you're thinking about talking with kids about AIDS:

A stands for Appropriate time — a planned talk or a special, "teachable moment"

I stands for Information — when you're not sure of the facts, it stands for "I don't know."

D stands for Discussion — talking to and really listening to your child

S stands for Supporting your child's self esteem!

The "teachable moment"

Try to find natural opportunities to bring up the topic of AIDS. For example:

During a general conversation about a related topic. Place AIDS information in the context of a conversation about health, sexuality, or things that frighten people—death, substance abuse, and so on. Reinforce family values at the time to place AIDS information in a more comprehensive context for the child.

Right after a television broadcast or newspaper article on AIDS. Show your willingness to discuss AIDS or any other topic in an open manner. Ask your child what he knows about AIDS and if he has any questions.

When you overhear a conversation or game about AIDS among children. Listen for the child's feelings about AIDS. Correct any misinformation and lower the child's anxiety about AIDS. Reinforce the values of compassion and respect for others and explain prejudice and harassment as unacceptable ways to deal with a disease and illness.

When children overhear an adult conversation about AIDS, you may want to discuss the topic with your children later to clarify the information or concerns for them.

Brainstorm: Kids share when...

Say to the participants, "Let's consider under what circumstances kids share their thoughts and feelings with us. We will make a list of the times and situations where, in our experience, kids are most likely to talk about what's on their minds."

List responses on newsprint. Focus on the *circumstances* that motivate the child to share thoughts and feelings, rather than the content of what is shared. For example, the list might read: bedtime, when my child is scared, when she is excited about something, bathtime, after dinner while we're doing dishes, in the car during a long drive, and so forth. Pause at the end and ask participants to think about how they recognize these good times for conversation and to think about the kind of feedback kids give them when meaningful conversations take place.

Exercise: Strength Bombardment

Introduce the Strength Bombardment exercise. Say to the participants, "Young people often give adults very clear feedback on what kinds of communication styles and techniques work and don't work. Think about their comments when a talk isn't going smoothly: 'You never listen to me.' 'Can't you do anything but lecture?' This exercise is a way to practice and develop some skills in telling kids that you've caught them doing something *right!* Positive feedback and affirmation feel good to kids and adults alike and often are the very things that keep discussions of difficult topics moving in a constructive direction."

Give each participant one success-list sheet, one set of stickers, and one pattern (bulls-eye or heart-shaped or human body-shaped pattern are available). Explain the procedure.

Each person writes down three successes they experienced when they were at the different ages listed on the sheet. These can be big successes or little successes. They should be things that people feel good about.

Working in groups of three, one person tells their abbreviated life story to the partners. The storyteller focuses on the successes that he or she listed, talking about each briefly.

After each success has been explained, the other partners will compliment the person on that success. Then the partners will write a keyword on a sticker representing a personal trait that the achievement represented and place the sticker on the pattern. Each partner will take a turn telling their achievement and getting rewarded with positive feedback.

For example, if the participant lists an achievement, "completed college while a single parent," the trait symbolized on the sticker might be "goal-oriented" or "commitment" or "staying power."

Draw group back together. Ask participants to discuss how it felt to receive positive feedback on their achievements. In closing, tell the group that this is a light, fun activity that helps people to experience how good it feels to be told they have done something right. This positive style can be used effectively in talking with young people, even when the conversation is about difficult or personal topics.

Strength Bombardment List

List three successes you've had during each time period.

Before the age of 5

1.

2.

3.

Before the age of 12

1.

2.

3.

Before the age of 20

1.

2.

3.

Before the age of 35

1.

2.

3.

During the last year

1.

2.

3.

During the last month

1.

2.

3.

During the last week

1.

2.

3.

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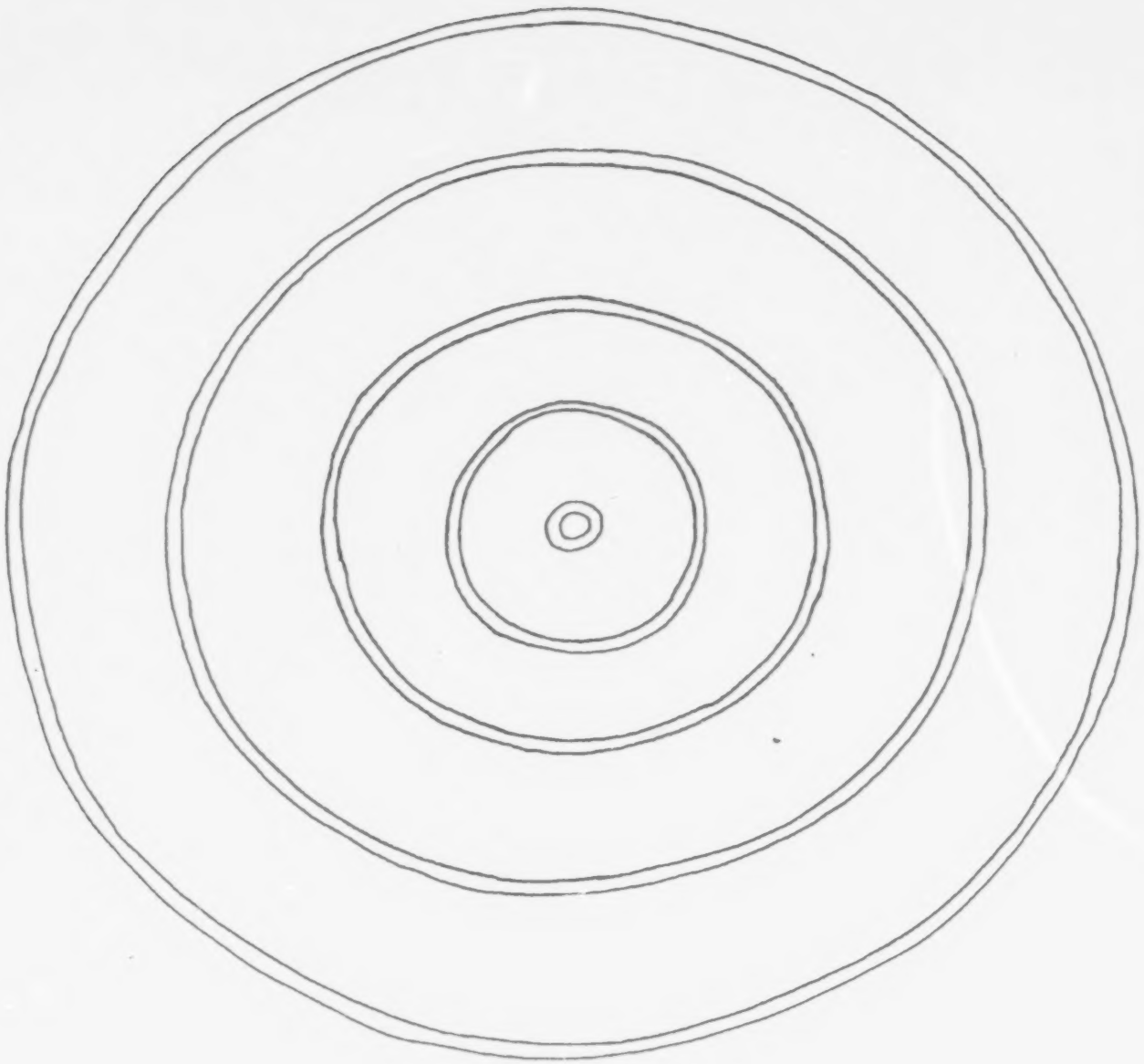

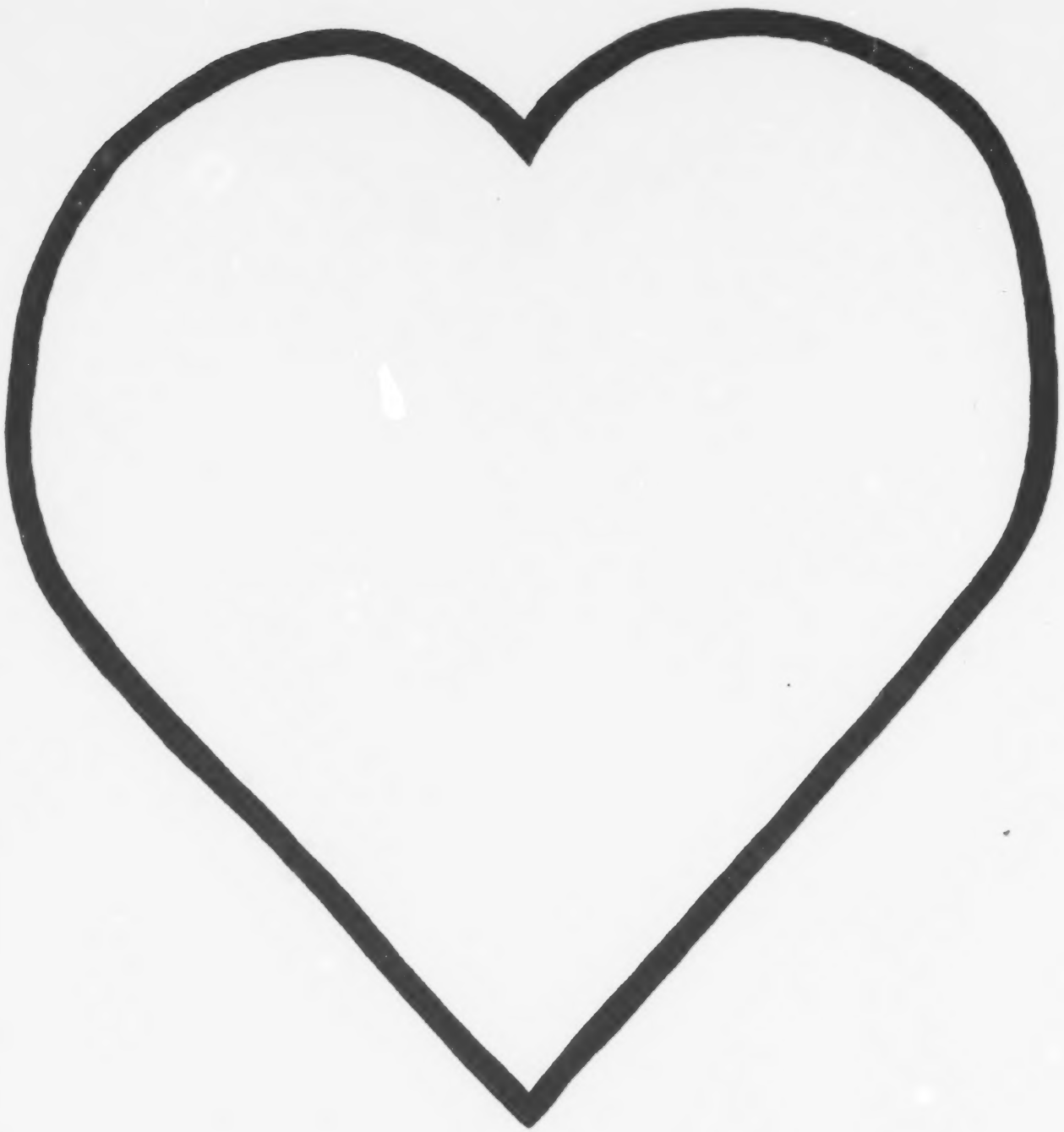

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Roleplays

Conversations with kids about risks and choices

Tell the group that this roleplay will involve several skills that participants have: their knowledge of HIV safety skills, their knowledge of their children, and the reality that children do not always do things that are consistent with adults' values. Each of the three people in the group takes turns so that each person experiences three roles: a young person, an adult who cares about that young person, and an observer. Each role has different responsibilities to fulfill.

The "young person" gets to set the stage. This person is to describe a risk/choice situation that a young person or child they care about may face; the situation they choose may be in conflict with adult values. These situations may or may not directly involve risks of HIV infection. They then act out the role of that young person.

The "adult" models responses to the young person, using positive communication techniques and correct information about AIDS and safety skills.

The "observer" keeps quiet during the roleplay and watches the other two actors. During discussion of the roleplay, the observer helps the young person and the adult to share their experiences of what communication techniques worked well or less well.

Allow time for participants to roleplay and briefly discuss three situations. Allow about five minutes for each situation. Each participant should take a turn in each role.

Bring the group together for a brief discussion of what they felt and learned during this exercise.

Brainstorm: A-I-D-S stands for . . . key elements in discussing AIDS with kids

Show the group four newsprint sheets with the following phrases printed on them:

- **A** stands for Appropriate time: Planned conversation or teachable moment
- **I** stands for Information. Sometimes it stands for "I don't know, I'll find out."
- **D** stands for Discussion
- **S** stands for Supporting self-esteem

Tell the group that this exercise provides an easy set of associations for thinking about the important parts of talking with their kids about AIDS. AIDS doesn't have to stand for only Acquired Immune Deficiency Syndrome. It can also stand for other things, such as these key parts of communicating with kids about AIDS!

Tell the group that next they will be making a specific plan for talking with their kids about AIDS. That plan will need to cover all of these things.

First, the group should brainstorm a few examples of each element.

List the ideas on each sheet of newsprint and leave the newsprint up on the wall while the group works on its plans. Tell them they can use these ideas as guides when doing their plans.

Plans for talking with kids

Ask the group to break into triads. Make sure that each person has a pencil and paper. Instruct people to work on their own for a few minutes to think about and represent on paper a plan for talking with their child or children about AIDS and HIV risk reduction. Each plan should include a time and place that would be good for having the conversation; ideas about information that they especially want to cover in the conversation; ideas about what topics and values they want to share and discuss with their child; and three specific ways they can support their child's sense of self-esteem before, during and after the conversation. After about ten minutes, ask each person to spend a minute telling their small group about the plan, and then a minute listening to the group's feedback, suggestions, and praise. Draw the whole group back together and spend about five minutes sharing ideas and insights on plans for conversations.

Round-robin: One good thing about my plan

Do a quick round-robin, asking each participant to say, "One good thing about my plan is...." This will provide some closure on the exercise, and begin to provide closure for the group. Give participants permission to pass and encourage them to think about what they are going to say first so they will be able to listen to others.

Post-test

Introduce the post-test and evaluation by saying that it will be a help to the AIDS education project if we can understand what people learn during these sessions, what people's feelings about the sessions are, and what we need to teach more clearly. Pass out the post-test and ask the group to spend a few minutes filling it out. Pass around an envelope for the post-test papers. Review the answers and ask if anyone has any questions.

Post-test: HIV/AIDS Prevention Facts

Please circle the correct answers to these questions.

1. Circle the four types of body fluids that *most often* carry HIV from an infected person to an uninfected person:

   blood
   vaginal secretions
   stomach acids
   sweat
   breast milk
   spit/saliva
   tears
   semen
   postnasal drip

2. On average, how long after people become infected with HIV do they become sick with AIDS?
   - **a.** exactly six months
   - **b.** eight to ten years
   - **c.** about two years

3. People with HIV can pass the virus to other people
   - **a.** from the time they are first infected.
   - **b.** only after they develop AIDS.

4. It is not who a person is, but what a person does that puts a person at risk of HIV infection.
   - **a.** This statement is true.
   - **b.** This statement is false.

5. What are some symptoms of AIDS or HIV disease?
   - **a.** Having a fever that lasts a month.
   - **b.** Losing one-tenth of your body weight without trying.
   - **c.** Having diarrhea that won't go away.
   - **d.** Sweating so much at night that the bedclothes are wet.
   - **e.** Having a dry cough and feeling short of breath.
   - **f.** Having "thrush" and/or vaginal yeast infections.
   - **g.** Losing your senses of direction and balance.
   - **h.** Having swollen lymph nodes (glands) for months.
   - **i.** All of the above.

6. If a person has HIV, AIDS, or any of these symptoms, it is important to go to a doctor or clinic for help.
   - **a.** This statement is true.
   - **b.** This statement is false.

7. What are some ways to reduce or eliminate sexual spread of HIV?
   - **a.** Abstinence from vaginal, anal, or oral intercourse.
   - **b.** Uninfected partners practicing monogamy.
   - **c.** Using latex condoms correctly during intercourse.
   - **d.** Practicing nonpenetrative sex.
   - **e.** All of the above.

8. How can someone keep hypodermic needles from transmitting HIV?
   - **a.** Not injecting drugs.
   - **b.** Not sharing hypodermic needles and syringes, ever.
   - **c.** Cleaning needles and works with bleach before using.
   - **d.** Using only sterile needles and syringes.
   - **e.** All of the above.

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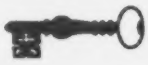

Facilitator's Key to Post-test: HIV/AIDS Prevention Facts

1. Blood, semen, and vaginal secretions are the body fluids that most often carry HIV from an infected person to an uninfected person. Babies can become infected after being breastfed by a woman with HIV.
2. **b.** eight to ten years
3. **a.** from the time they are first infected
4. **a.** This statement is true.
5. **i.** All of the above.
6. **a.** This statement is true.
7. **e.** All of the above.
8. **e.** All of the above.

Evaluation and closing

Evaluate today's session and the series as a whole. Using newsprint, ask participants what was useful to them about this session and what could have been better. Ask them what they would like to see included in a series that might be offered for other people.

Tell the group that the program will sponsor follow-up activities for them and for their children about AIDS education. Ask the group to think of ways they might want to work on AIDS education in the future. Review the local resource list for sources of more information, support, and volunteer opportunities.

Closing circle: Ask each person to describe one thing they have enjoyed about the group and working with other members.

Thank participants. Congratulate them on being a good group and tell them you look forward to seeing them again at other AIDS education events. Let them know you are pleased that they are so interested in teaching young people about AIDS and safety skills, because their efforts are important.

GLOSSARY

This glossary provides definitions for words that are commonly used when HIV and AIDS are discussed. Some terms that are rarely used anymore because they are potentially misleading, such as "high-risk group," are defined because they are found in earlier literature about AIDS.

AIDS (Acquired Immune Deficiency Syndrome)
A condition caused by infection with Human Immunodeficiency Virus (HIV). HIV injures cells in the immune system. This impairs the body's ability to fight disease. People with AIDS are susceptible to a wide range of unusual and potentially life-threatening diseases and infections. These diseases can often be treated, but there is not yet a successful treatment for the underlying immune deficiency caused by the virus.

Antibodies
These are proteins that the body makes to attack foreign organisms and toxins. Foreign organisms and toxins are called antigens. They circulate in the blood. Antibodies are usually effective in removing antigens from the body. In infection by some organisms such as HIV, however, the antibodies do not get rid of the antigen. They only mark its presence. When found in the blood, these "marker" antibodies indicate that infection by HIV has occurred.

Antigen
Any substance—such as bacteria, virus particles, or some toxins—that stimulates the body to produce antibodies. HIV is an antigen.

Antigen Screens
Blood tests that are designed to detect the antigen instead of antibodies produced in response to the antigen. There are several types of HIV antigen screens.

ARC (AIDS Related Complex)
This term refers to the condition of immunosuppression caused by HIV infection. General symptoms of HIV disease are present, but none of the formal indicators of AIDS (such as specific opportunistic infections) are present. This term is now being replaced by PGL (Persistent Generalized Lymphadenopathy).

Asymptomatic
Having no signs and symptoms of illness. People can have HIV infection and be asymptomatic.

Body Fluids
Any fluids made by the body. The only body fluids that are able to carry HIV into another person's system and cause infection are blood, semen, vaginal secretions, menstrual blood, breast milk, and body cavity fluids derived from blood such as cerebrospinal fluid, peritoneal fluid, amniotic fluid, etc. In talking about HIV infection, it is more effective to say "blood," "semen," or "vaginal secretions" than to use the general term "body fluids."

Candida
A yeast organism that lives in people's intestines. It can begin to grow in other parts of the body if a person is immunosuppressed. When Candida infects the mouth or esophagus, it is sometimes called "thrush." When Candida infects a woman's vagina and vulva, it is often called a "yeast infection."

CDC (Centers for Disease Control)
A federal health agency that is a branch of the U.S. Department of Health and Human Services Public Health Service. The CDC provides national health and safety guidelines and statistical data on AIDS/HIV and other diseases and health conditions.

CNS (Central Nervous System)
The CNS is made up of the brain and spinal cord. HIV has been found in the fluid surrounding the CNS and is believed to cause symptoms such as loss of coordination and balance, headaches, dementia, loss of recent memory and problem-solving abilities, and loss of hearing, speech and visual abilities. HIV is able to directly infect nerves and apparently does so in the CNS. Not all viruses are able to enter or infect the CNS, but HIV can.

Co-factor
A situation or activity that may increase a person's risk for progressing from asymptomatic HIV infection to symptomatic disease and AIDS. Examples of possible co-factors are other infections, drug and alcohol use, homelessness, poor nutrition, genetic factors, other systemic diseases, stress, surgery, or trauma.

ELISA Test
A blood test that detects the presence of antibodies to a specific antigen. An ELISA test is used to screen blood samples for the presence of antibodies to HIV. The test discovers HIV infection, not the symptoms of AIDS. The test is used for screening blood supplies and for seroprevalence studies. Sometimes it is employed in

specific health care and diagnostic situations. If the ELISA test for HIV antibody comes back positive (detects antibodies), a confirmatory test is then done on the blood sample (see "Western Blot.")

Epidemiology
The study of how diseases are spread.

False Negative
An incorrect test result that indicates that no HIV antibodies are present when in fact infection has occurred.

False Positive
An incorrect test result that indicates that antibodies are present when in fact there are none.

Hemophilia
An inherited condition in which a person's blood fails to clot effectively. Hemophiliacs often receive treatments with a blood product called Factor VIII. This puts clotting factors from other people's blood into their blood so that their blood clots effectively. Factor VIII is made from the combined blood of many individuals. Many hemophiliacs became infected with HIV when they were treated with clotting factor containing the virus. All clotting factor made in the United States is now heat-treated to kill the virus.

High-Risk Behavior
A term used to describe activities that increase a person's risk of transmitting or becoming infected with HIV. Examples of high-risk behaviors include oral, vaginal, or anal intercourse without a condom, sharing injection needles, and so on. These are also often referred to as "unsafe" activities.

High-Risk Groups
This is an old and potentially misleading term. It refers to groups in which epidemiological evidence indicates that more people have been infected with HIV. In prevention, it is important to stress high-risk behaviors rather than high-risk groups. It is not groups but behaviors that transmit HIV.

HIV (Human Immunodeficiency Virus)
Infection with HIV injures the immune system, causing AIDS. This standard name was officially chosen in August 1986 to avoid confusion after different researchers in different countries gave the virus different names. You may see the virus referred to as HTLV-III (Human T-Cell Lymphotropic Virus Type Three), LAV (Lymphadenopathy Associated Virus), or ARV (AIDS-Related Virus) in old literature.

Incubation Period
The time it takes for symptoms of a disease to develop after infection. The incubation period in AIDS can vary from several months to many years. The average incubation period is believed to be about nine years.

KS (Kaposi's Sarcoma)
Many people with AIDS experience this cancer of the connective tissues in blood vessels. Pink, brown, or purple blotches on the skin may be a symptom of KS. KS lesions sometimes occur inside the body in lymph nodes, the intestinal tract, and the lungs.

Leukocytes
Commonly called white blood cells, leukocytes play a major role in fighting disease. Lymphocytes are one subcategory of leukocytes. The two types of white blood cells often discussed in relation to AIDS are T-cells and B-cells.

Lymphadenopathy
Swollen lymph nodes.

Lymphocytes
White blood cells found in the lymph nodes and bone marrow. Lymphocytes are divided into two groups: B-lymphocytes, which produce antibodies, and T-lymphocytes, which are involved in directing the immune response.

Nonoxynol-9
A spermicide that has been demonstrated to kill HIV during laboratory tests. Sometimes it causes irritation and inflammation of mucous membranes.

Opportunistic Infections
Infections caused by organisms that do not normally cause disease in people whose immune systems are intact. In New York State, the most common opportunistic infections indicating that someone has AIDS are PCP (Pneumocystic Carinii Pneumonia), Esophageal

candidiasis, Cryptococcal meningitis, Mycobacterium avium complex, Toxoplasmosis, and CMV (Cytomegalovirus).

Oral Sex
Sexual activity in which the mouth of one person comes into contact with another person's penis, vulva, or anus.

PGL (Persistent Generalized Lymphadenopathy)

A phase of HIV disease in which people experience chronic swollen lymph nodes in several areas of their body. Generalized symptoms of HIV disease might also be present, but no major opportunistic infections have occurred because the immune system is still functioning relatively effectively. This phase of HIV disease has sometimes been called ARC.

PWA (Person with AIDS)
The PWA Coalition explains why many people living with AIDS prefer this term: "We challenge the label *victim*, which implies defeat, and we are only occasionally *patients*. We are people with AIDS."

Retrovirus
A type of virus that is able to insert its genetic material into a host cell's DNA. Retrovirus infections had not been found in human beings until recently. HIV is a retrovirus.

Risk Reduction
The process of adopting behaviors that reduce the likelihood that an individual will be exposed to HIV.

Safer Sex
Sexual activities that are not likely to transmit HIV. Safer sex involves sexual expressions in which partners make sure that blood, semen, vaginal mucus, and menstrual blood from one person do not come into contact with the other person's bloodstream or mucous membranes (vulva, vagina, rectum, mouth, nose).

Safety Skills
Risk reduction methods. Safer sex, not sharing needles, cleaning needles, and practicing universal precautions at work are all safety skills.

Seronegative
Testing negative for HIV antibodies (antibodies are not detected).

Seropositive
Testing positive for HIV antibodies (antibodies are detected).

Seroprevalence
The rate of seropositivity in a defined population. Suggests the rate of HIV infection for that population.

Spermicide
A contraceptive that works by killing sperm in semen. Some spermicides, such as nonoxynol-9, have also been demonstrated to kill HIV in laboratory tests.

T cell
One type of white blood cell. One type of T cell (T-4 Lymphocytes, also called Helper T cells) is especially apt to be infected by HIV. By injuring and destroying these cells, HIV damages the overall ability of the immune system to fight disease.

Treatment
There is no known way to remove HIV from the body once a person has been infected, or to cure AIDS by restoring all the abilities of the immune system after it has been damaged. However, many drugs and treatments are being used in experimental trials to determine how well they work against HIV infection and opportunistic diseases. Treatments fall into several categories: Antiviral treatments focus on destroying or inactivating HIV. Immunosupportive treatments attempt to rebuild or boost the immune system. There are also drugs used to treat or control the opportunistic infections and cancers that people with AIDS experience. Often all these types of treatment are used in combination.

Unsafe Sex
See "High-Risk Behavior."

Western Blot
A blood test used to detect antibodies to HIV. In New York State, this test is used to confirm the results of all positive ELISA tests. Their combined accuracy is 99 percent.

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RESOURCE MANUAL

Talking with Kids about AIDS

A Program for Parents and Other Adults Who Care

By
Jennifer Tiffany
Donald Tobias
Arzeymah Raqib
Jerome Ziegler

Illustrations by Marcia Quackenbush

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The companion volume to this resource manual is *Talking with Kids about AIDS, Teaching Guide.*

* * * *

This book is dedicated to Kathy Keris and Chris Gaillardet.

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CHAPTER 1

Chapter 1. What Is AIDS?

Why do people need to be concerned about AIDS (Acquired Immune Deficiency Syndrome)? AIDS is a life-threatening condition that usually develops eight to ten years after a person has been infected with HIV (Human Immunodeficiency Virus). HIV causes AIDS by damaging people's immune systems. People with HIV become vulnerable to infections and cancers that take advantage of their damaged immune system. Once a person is infected with HIV, she or he carries the virus for life. There is not yet a cure for HIV infection, although there are treatments for some of the conditions it causes. The best way to prevent AIDS is to prevent HIV infection.

HIV infection is spreading rapidly throughout the world. Citizens of 169 countries have already been diagnosed with AIDS, according to the World Health Organization (WHO). The WHO estimates that thirteen million people throughout the world already have been infected with HIV and fears that 30 to 40 million people may be infected by the year 2000. Almost everyone will learn sometime during the next few years that someone he or she knows has HIV/AIDS. People in every community will face the illness. So, AIDS is everyone's concern.

This book presents basic, reliable facts about AIDS and about how HIV infection can be prevented. We also discuss how adults can help children and young people to avoid becoming infected, because, worldwide, young people are very much at risk of becoming infected with HIV.

For both young people and adults, HIV is most often a sexually transmitted disease (STD). The virus is spread sexually when blood, semen, or vaginal secretions containing HIV get inside an uninfected person's body. This usually happens when people have vaginal or anal intercourse and do not use a latex condom. Oral-genital sex with both men and women can also spread the virus. In this book we discuss ways people can prevent sexual transmission of HIV and explain how adults can teach their children about reproduction, sex, and sexuality.

People also are at risk of infection if they share needles for any purpose whatsoever. Any action that allows blood from one person to get inside another person's body can transmit HIV. In the United States, most needle-sharing happens when people inject street drugs. We discuss ways to reduce or eliminate the spread of HIV through needle-sharing.

How is HIV transmitted?

To get AIDS, a person must be infected with HIV. Being infected means the virus has entered the cells of a person's body. The virus most often lives in special kinds of white blood cells. The body fluids that commonly carry enough virus particles to cause infection are blood, semen, and vaginal secretions. Blood can carry the highest concentration of virus particles. Menstrual blood may have a large amount of virus in it if the woman is infected with HIV. Cerebrospinal fluid or the fluid around the heart or lungs also can contain the virus, but people are very rarely exposed to them. Semen from a man who is infected with HIV contains many virus particles, especially if he has any kind of urinary tract infection. Vaginal secretions carry lower levels of virus than blood or semen but enough to pass HIV to another person, especially if the woman has a vaginal infection. Infections of the urinary and reproductive systems, including many sexually transmitted diseases, mean that white blood cells are drawn to the genital area to fight the infection. Since HIV lives in white blood cells, more HIV-infected cells may then be present.

HIV transmission can happen	Transmission can be prevented by
• during sexual intercourse (vaginal, anal, oral) where semen, vaginal secretions, or blood from an infected person enter the body of an uninfected person.	• not having intercourse; using latex condoms during intercourse; having sex only with an uninfected partner.
• through sharing hypodermic needles where blood from an infected person is injected into an uninfected person (IV drug use, using steroids or insulin, tattooing).	• not sharing needles or syringes; sterilizing needles and syringes properly; cleaning needles and syringes with bleach and water (this will kill the HIV but won't make the hypodermic needle sterile).
• during pregnancy and childbirth when a mother with HIV may pass the virus from her bloodstream to her baby.	• having an HIV antibody test before becoming pregnant.
• during breastfeeding when the woman has HIV.	• having an HIV antibody test before breastfeeding; feeding infant formula.
• through injuries in which health care workers get infected blood inside their bodies by being stuck with a used needle or splashed in the eyes or mouth with blood.	• disposing of "sharps" carefully in a solid plastic container; wearing gloves if touching blood, semen, or vaginal secretions; wearing masks and goggles as necessary.
• during transfusions of blood or clotting factor. All U.S. blood supplies began to be tested for HIV antibody in March 1985.	• banking blood for elective surgeries. Current risk of HIV infection is 1 in 39,000 per unit of blood. Donating blood is safe.

Most babies with HIV got the virus from their mothers during pregnancy or delivery. Babies also have become infected when breastfed by women with HIV.

HIV and AIDS don't discriminate: Anyone can become infected if blood, semen, or vaginal secretions containing the virus enter the body. The most common ways people become infected are by having unprotected intercourse or by sharing hypodermic needles with someone who has the virus. It is very important that everyone know about HIV prevention, teach about HIV prevention, and practice HIV prevention.

For more information on HIV transmission, read on! The next section gives details on how exposure to blood, semen, and vaginal secretions can transmit HIV.

Blood carrying HIV must enter a person's bloodstream to cause infection. The ways this may happen include

- Sharing needles and "works" used for preparing and injecting intravenous drugs. Sometimes, blood from one person is drawn up into the needle and syringe and remains there when the syringe is passed along to the next person. That blood is then injected straight into the next person's bloodstream, along with the drug. This is one of the most efficient ways for HIV to be passed from person to person. At least 5 percent of IV drug users in the United States and more than 50 percent of IV drug users in New York City are already infected with HIV. In Bangkok, Thailand, the HIV infection rate among IV drug users jumped from 2 percent to 40 percent in only a few months. These statistics show how dangerous sharing needles and works can be!

- Sharing needles used for injecting nonintravenous drugs ("skin-popping") or for other activities such as tattooing or ear-piercing. Although less risky than sharing IV needles, the small (even invisible) amounts of blood on and in these needles could spread HIV from one person to another. Remember, it is not the recreational drug use that presents the risk of HIV infection—it is the blood on the shared needle. Sharing needles to inject insulin is risky. Sharing needles to inject anabolic steroids is risky. Reusing needles in clinics and vaccination campaigns in poor countries has put many adults and children at risk of HIV infection because they were exposed to small amounts of other people's blood.

- Before there were ways of screening donated blood for HIV, some infected blood was used in transfusions. Some infected blood also was used in preparing blood products such as the clotting factor that hemophiliacs need. Since 1985, all donated blood has been carefully screened for HIV antibody (a substance produced by the immune system if a person has been infected with HIV). Some blood products are now heat-treated to make sure they do not contain HIV.

- Some health care workers and lab technicians have been exposed to HIV-infected blood through workplace accidents, such as needle-stick injuries. Usually, these accidents involve relatively small amounts of blood. About one in every two hundred people exposed to HIV this way becomes infected. So far, it is known that 32 U.S. health care workers who were infected with HIV while on the job have developed AIDS.

Hemophilia and HIV

About one in every ten thousand babies born in the United States has hemophilia. Babies with hemophilia inherit a genetic trait that prevents their blood from clotting effectively. A person with hemophilia may bleed a great deal from what seems like a minor injury.

Because hemophilia is a sex-linked trait, more males than females experience the clotting disorder. One in every four thousand boy babies born is a hemophiliac. The National Hemophilia Foundation estimates that there are about 20,000 people diagnosed with hemophilia in the United States.

The bleeding that people with hemophilia experience can threaten their life and health. To help their blood clot faster, people with hemophilia receive clotting factor treatments. The clotting factor which they receive is made from blood contributed by a large number of other people.

Before anyone knew that HIV was carried in blood, clotting factor that contained HIV was given to many people with hemophilia. As many as 70 percent of the people with severe type-A hemophilia in the United States received clotting factor containing HIV and became infected. As many as 35 percent of people with milder type-A or type-B hemophilia became infected.

Since 1985, blood used to make clotting factor needed by people with hemophilia has been tested for HIV antibody, and clotting factor is now heat-treated to make certain that it contains no living HIV.

About 1 percent of all people with AIDS have hemophilia. About 6 percent of children with AIDS have hemophilia. Many of the widely publicized situations in which children with AIDS were kept out of school or harassed involved children with hemophilia. Like other groups of people who have been identified as especially at risk for HIV, people with hemophilia experience AIDS-related discrimination.

The National Hemophilia Foundation and local hemophilia societies often sponsor support groups for people and families affected by AIDS. Often they can provide excellent educational materials.

• Newborns with HIV usually have become infected by exposure to virus from their mother's blood. Approximately one third of babies born to women with HIV go on to develop AIDS. Blood tests for antibodies to HIV done soon after babies are born show whether or not the mother is infected. These blood tests don't show whether the newborn has the virus or will go on to develop AIDS. This is because passive transfer of antibodies from mother to infant occurs before the baby is born.

This transfer of antibodies from the mother's bloodstream helps the newborn to resist many kinds of infections while its own immune system is developing. Almost all babies born to mothers who have antibodies to HIV receive HIV antibodies during the passive transfer. Antibodies to HIV do not guarantee immunity or effectively protect the body from HIV, but they do act as markers to show that the person was exposed to the virus and infected.

After 15 to 18 months, the baby loses the antibodies it inherited from its mother, because they are no longer needed. The baby's own immune system begins to function well enough to protect it from common infections. At this age, many infants who tested positive for HIV antibodies at birth no longer test positive. They have lost the antibodies inherited from their mothers and have not produced their own.

Most of these babies were not infected with the virus at all and have healthy immune systems. A few of these babies have HIV but have not produced their own antibodies to it, possibly because their immune system has already been harmed by the infection.

Researchers are currently trying to learn the reasons why some infants born to mothers with HIV remain free from the infection.

Semen from a man with HIV can enter another person's system and spread the virus in the following ways:

• Vaginal intercourse without a latex condom allows HIV in semen and pre-ejaculate to enter a woman's bloodstream. HIV can directly infect immune system cells in the vagina, which then carry the virus into the vaginal walls, cervix, and bloodstream. Also, small, even invisible, cuts or tears in the vaginal wall or cervix may let HIV from the semen go directly into the bloodstream of the woman. Sometimes the vaginal walls are especially delicate, with blood vessels very close to the surface. Lack of lubrication during penetration can make small cuts likely. STDs, other infections, and any trauma to the vaginal walls also make it easier for HIV to enter the woman's bloodstream.

• Anal intercourse without a condom allows HIV in semen and pre-ejaculate to enter the bloodstream around the rectum. The rectal wall is very delicate and blood vessels are near the surface. The semen may enter the bloodstream directly through tears, even tiny tears, in the rectal wall. Also, HIV in the semen may directly infect white blood cells in the rectum, which then can carry the virus through the rectal wall. As with vaginal penetration, lack of lubrication, trauma, and the presence of other infections may make it easier for HIV from the semen to enter the bloodstream around the rectum. Anal intercourse may be practiced by two men or by a man and a woman.

• Oral sex on a man ("giving head," "blow job," fellatio) without a latex condom can result in HIV transmission. If pre-ejaculate or semen containing HIV enters the mouth, the virus can infect cells of the mucous membrane that lines the mouth whether or not there are cuts, sores or abrasions. Ejaculation can expose mucous membranes of the throat and sinuses to semen as well.

• Artificial insemination with semen from men with HIV has resulted in women becoming infected with HIV. As with blood, sperm donors now are routinely screened for HIV infection by most sperm banks.

Vaginal secretions and menstrual blood from a woman with HIV can pass the virus in the following ways:

• Vaginal intercourse without a latex condom may allow the virus to enter a man's bloodstream through small cuts and abrasions on the penis. Vaginal secretions or menstrual blood may enter the man's urethra (the opening through which urine and semen travel) during unprotected intercourse. The virus can then enter his bloodstream through the mucous membrane of the urethra. Lack of lubrication, STDs or other infections, and trauma causing sores on the penis make transmission of HIV more likely. Some doctors think that men who are not circumcised may become infected more easily because the foreskin of the penis holds vaginal fluids.

• Oral sex on a woman ("going down," cunnilingus) may transmit HIV from a woman to her partner. The virus from vaginal secretions or menstrual blood may get into cuts on the partner's lips. HIV could also pass through the mucous membrane lining the mouth and infect the partner whether or not cuts or sores are present.

• Vaginal secretions or menstrual blood on a vibrator or dildo that is then used by another person for vaginal or anal penetration may also transmit the virus.

How HIV is not transmitted

HIV is a relatively weak virus and can live in only a few kinds of cells. It dies very quickly when it is outside of the body. HIV is not spread from person to person either by casual contact (sharing telephones, swimming in pools, using toilets, shaking hands, hugging, playing sports, social kissing) or by household contact that may be fairly intimate (for example, toddlers with HIV live with other toddlers and do all kinds of things together, including wrestling, chewing on the same toys, etc.). Even activities that are thought to present some risk of transmitting HIV, such as sharing razors and toothbrushes, have never been known to spread the virus. Deep kissing has not been known to spread the virus. Potential risk factors for deep kissing include the possibility that blood containing HIV from one person's bleeding gums could enter another person's body through small cuts or sores in the mouth. Safety factors in deep kissing include the ability of substances in saliva to break down viruses and bacteria. Laboratory research has found that saliva can block HIV from infecting white blood cells.

What happens when a person has HIV infection?

People who have been exposed to HIV through sexual intercourse or needle-sharing may or may not become infected. Some people have become infected after only one exposure, while other people have been exposed many times and have not gotten the virus. A newly infected person may feel and seem perfectly healthy. Most people with early HIV infection have no symptoms. Sometimes people may feel frightened because they recognize that they have risked HIV infection by not taking precautions. Sometimes people have symptoms of acute infection a few weeks or months after they were exposed. These symptoms are like a bad case of the flu or "mono" that lasts for a couple of days to two weeks. Because the same symptoms occur with many kinds of viral infections, including hepatitis and the flu itself, it is difficult for people or their doctors to tell whether or not they are experiencing acute HIV infection. Most people who have just been infected with HIV don't notice any changes in their health. But they can pass the virus on now if they share needles, have intercourse without a latex condom, or donate blood, semen, or body parts.

As the virus enters a person's body, it infects only a few kinds of cells, especially ones that have a special kind of protein in them. This protein, called CD-4, is found most often in a type of white blood cell, called T-4 Lymphocytes or Helper T cells. It is also found in some nerve and brain cells. At first, the virus may infect many of these cells and cause symptoms such as a temporary drop in the body's ability to fight off disease or temporary central nervous system problems.

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The Continuum of HIV Infection and HIV Disease

1. Infected with HIV.
2. Produce HIV antibodies that can be measured on the antibody test. (Usually 2–12 weeks after infection, sometimes up to 6 months, occasionally longer)
3. Feel physically healthy. Immune system tests healthy. (Usually 1–8 years from infection)
4. Feel physically healthy. Immune system shows signs of suppression. (Usually 2–8 years from infection)
5. Initial symptoms. (Usually 3–10 years from infection)
6. Severe immune suppression. Possible AIDS diagnosis. (Usually 8–12 years from infection)
Eleven years after infection, 341 members of the San Francisco cohort study were in the following phases of illness:
59% diagnosed with AIDS (49% deceased, 10% alive)
19% symptoms of illness
3% swollen lymph nodes but no other symptoms
19% no symptoms of illness

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Soon after infection with HIV, the body begins to respond to protect itself. It makes antibodies to HIV (the same way as it makes antibodies to tetanus after a vaccination or to viruses that cause the flu). The antibodies to HIV, however, don't work as well as antibodies to other disease-causing organisms. This is because HIV changes its outside envelope in ways that keep antibodies from recognizing it. Also, HIV is a kind of virus that can hide in the cells it infects. HIV is a retrovirus, which means that it can bury its genetic material in the genetic material of its host cell. HIV can stay latent for a long time, not actively reproducing itself or causing disease but still present in a person's body.

The antibodies produced in response to HIV can be detected in blood tests. The ELISA test is used to screen blood samples for the presence of antibodies to HIV. The test does not tell whether or not the person has symptoms of AIDS, only if he or she has been infected with the virus. The test is used to screen blood supplies and for studies to judge how many people have HIV infection. The test is also one of several used by health care workers to find out if patients are suffering from HIV. If the ELISA test for HIV antibody is positive, a confirmatory test known as the Western Blot is then done on the blood sample. The Western Blot test detects antibodies to HIV and is used to confirm the results of all positive ELISA tests in New York State and many other parts of the world. The two tests, used together, are 99 percent accurate.

Most people produce enough antibodies to be detected by these tests within two to twelve weeks of infection with HIV. The production of these antibodies is called seroconversion. Very rarely, people may not have detectable levels of HIV-antibody in their blood until six months or more after infection, especially if they have some other health condition that interferes either with producing antibodies or with keeping the antibodies in their bloodstream at high levels. Scientists are working to develop tests to detect HIV itself that are as accurate and inexpensive as the antibody tests.

HIV Antibody Testing: What Can It Tell You?

A positive HIV antibody test means that your body has produced antibodies to the Human Immunodeficiency Virus. The presence of antibodies means that you are carrying the virus in your system and that you can pass the virus on to other people if your blood, semen, or vaginal secretions get into their bodies. You may want to seek treatment for the HIV infection because early treatment can help to keep you healthy. You should take care of your health, and you should be careful not to put other people at risk of becoming infected with HIV. A positive test does not mean that you have AIDS or that you are sure to get AIDS. It doesn't mean that you are immune to HIV. You should take care not to be exposed to new infection with HIV from other people, because repeated infection with HIV can harm your health even more.

A negative test means that your body is not producing antibodies to HIV. This may mean you have never been infected. If you have been at risk for infection recently, however, it may mean that your body is just beginning to respond to HIV and hasn't yet produced antibodies to the virus. A negative test does not mean that you are immune to AIDS or that you have a resistance to infection with HIV. You should be careful not to risk exposure to HIV infection. It is important to be retested if you could have become infected during the six months before you took the test.

After becoming infected and beginning to produce antibodies to the virus, many people appear healthy and feel fine for years. The virus may stay completely latent, or it may begin to do some damage to their immune systems. After infection with HIV, many people begin to have swollen lymph nodes. Sometimes people experience other "constitutional" (general) symptoms during this time, such as diarrhea, fever, tiredness, weight loss, and sweating so much at night that their bedclothes are soaked.

As time passes, HIV may damage more and more immune system cells. People may first experience skin and mucous membrane problems, such as thrush (oral candidiasis), fungus infections on the skin, or vaginal yeast infections. A weakened immune system makes people with HIV very vulnerable to diseases such as tuberculosis, pelvic inflammatory disease, bacterial pneumonia, or salmonella, which also can affect people with healthy immune systems. People with HIV may be more vulnerable to specific cancers, including Kaposi's sarcoma, cervical

cancer, and non-Hodgkins lymphoma. The treatments needed for these illnesses may be different from those designed for people without HIV. People in this phase of HIV disease may face illnesses that are life-threatening, even if they are not diagnosed with AIDS.

General Symptoms of AIDS and HIV Disease

Symptoms of AIDS and HIV disease include

- Unexplained, persistent, extreme fatigue.
- Unexplained fever, shaking chills, or drenching night sweats lasting longer than several weeks.
- Unexplained weight loss of more than 10 pounds over a few months.
- Enlarged lymph nodes (swollen glands) that stay swollen.
- Pink, purple, or brown flat or raised blotches or bumps on or under the skin, inside the mouth, nose, eyelids, or rectum. They seem to be bruises at first, but they don't disappear. They usually feel harder than the skin around them.
- White spots or curds or a feeling of being scalded inside the mouth.
- Vaginal yeast infections that return after treatment.
- Diarrhea that doesn't go away or comes and goes.
- Changes in memory, ability to see, balance, sense of direction, or handwriting.
- A dry cough that lasts longer than a cold or upper respiratory infection.
- Shortness of breath.

Many of these symptoms accompany other illnesses, including common ones such as colds or the flu. In HIV disease these symptoms tend to be fairly severe and to continue for a long time or to disappear and then return. Anyone concerned about these symptoms should see a health-care provider familiar with AIDS and HIV-related conditions. Whether or not these symptoms are related to AIDS, it may be important to seek medical help in treating them and figuring out their cause.

AIDS is a name for the extreme phases of HIV disease, when the immune system is so damaged that people are vulnerable to illnesses caused by organisms that would not harm people with healthy immune systems. These illnesses are called opportunistic infections because the germs that cause them are taking advantage of an immune system that has been badly weakened by HIV.

People may be diagnosed with AIDS if they have central nervous system problems, extreme weight loss, Kaposi's sarcoma (a rare kind of skin cancer), invasive cervical cancer, or an opportunistic infection such as Pneumocystis carinii pneumonia (PCP). An average of ten years may pass between infection with HIV and development of these extreme symptoms. Because of this long latency period it is extremely important that people take prevention seriously. A person may have HIV infection and feel well or not be diagnosed with HIV-related diseases for a long time. The virus can be transmitted anytime during this period.

No one knows whether or not everyone who has HIV will get this sick. There is still a great deal to learn about how HIV infection affects people's health.

What about treatments and cures for HIV?

AIDS was first identified in 1981. Because it is a life-threatening infectious disease, much research has been directed toward understanding exactly how the virus that causes AIDS is and is not spread. HIV transmission is now very well understood. What researchers must learn more about is exactly what happens to people who are infected with HIV and how the illness can be treated. A major goal is to develop a cure or vaccine that will help infected people get rid of the virus.

Currently, there is no cure for HIV infection. Once the virus is in a person's system, it cannot be removed. As researchers learn more about the symptoms that people experience when they have HIV, however, more effective treatments for these symptoms can be developed. Currently, drugs are used that help to keep HIV from multiplying and damaging more cells (AZT), that help to strengthen the immune system (Interferon), and that help stop opportunistic infections from happening (Pentamidine). Drugs are being tested that may help keep HIV from infecting cells. Researchers are also examining factors that may speed up or slow down the progression of HIV disease from asymptomatic infection to AIDS. Smoking, alcohol and cocaine use, poor nutrition, other infections, and stress may speed up progression of the disease.

How can people prevent HIV transmission?

If people become infected with HIV, they are able to pass the virus on to other people. That is one reason why precautions such as the ones described in the next section are important. Because so many people already have HIV, it is important for everyone to understand how the spread of HIV can be reduced. Prevention measures do work. It may help to think of HIV as a sexually transmitted disease (STD) rather than as a "special" disease. The measures that prevent the transmission of STDs such as gonorrhea and syphilis—use of latex condoms during intercourse or practicing nonpenetrative "safe sex"—also prevent the sexual transmission of HIV.

People who do not need to take precautions themselves need to know about these safety skills so that they can teach them to other people they care about.

Safety skills for preventing exposure to blood.

• Many people have become infected with HIV by sharing needles and syringes to inject drugs. For complete safety, needles or works should not be shared with anyone, ever. There are many more people who are addicted to injectable drugs than there are places in treatment programs. Until this situation is corrected, some people recommend programs that reduce the risk of HIV transmission even though they do not remedy drug addiction. These risk-reduction techniques include distribution of sterile needles to people who are addicted to injectable drugs and distribution of needle cleaning kits and information.

Needles and works can easily be cleaned so they are free of HIV by the 2 + 2 method. Chlorine bleach is drawn up into the syringe twice and squirted out. Then plain water is drawn up twice to flush out the bleach (see illustration). HIV and other organisms in needles and works also can be killed by boiling them in water for 15 minutes.

Some programs distribute needle cleaning kits and fresh chlorine bleach to drug users for free. This is one way to help drug users and people in shooting galleries to protect themselves from HIV infection.

• Two percent of the adults and seven percent of the children with AIDS in the U.S. were infected when they received blood products containing HIV. According to the Centers for Disease Control, the current risk of being infected with HIV through a blood transfusion is about 1 in 39,000. This small risk remains because of the "window period" between infection with HIV and the immune system's production of HIV antibody. Many hospitals will help patients to bank their own blood before elective surgery. Some surgeons are working on ways to reduce blood loss during any surgery to a minimum. Remember: If you need an emergency

1. BLEACH
BLEACH
• FILL SYRINGE
• EMPTY SYRINGE
2. BLEACH
BLEACH
• FILL SYRINGE
• EMPTY SYRINGE

1. WATER
• FILL SYRINGE
• EMPTY SYRINGE
2. WATER
• FILL SYRINGE
• EMPTY SYRINGE

2+2 method

transfusion, the risk of becoming exposed to HIV is probably very small compared to the risk to your health if you don't get the transfusion.

- Thirty-two health care workers in the U.S. have developed AIDS after becoming infected with HIV during a workplace accident. Health care facilities and laboratories have implemented "universal precautions" that reduce workers' risk of on-the-job exposure to HIV, Hepatitis B virus, and other bloodborne diseases. It is especially important that good methods of disposing of used needles and other sharp instruments be provided by all workplaces.

> Approximately one third of babies born to women with HIV develop AIDS. Some research suggests that women with HIV who become pregnant may also risk becoming sicker faster. Other research finds no impact of pregnancy on disease progression. More research is needed in this area before it is clear what choices may be best for women with HIV who wish to become pregnant. Women with HIV should consider not breast-feeding infants, as HIV can be transmitted to babies through breastfeeding. Many milk banks now treat the breast milk they distribute to make sure that it does not contain the virus. Breast-feeding is still best in situations where people cannot afford enough formula for babies to drink or where the formula cannot be mixed and stored safely. Breast milk contains antibodies that help protect babies from common infections and usually helps keep babies healthy.

Safety skills for preventing exposure to semen

- Some people choose to abstain from penetrative sex. HIV has not been spread between sexual partners who don't have vaginal, anal, or oral intercourse and who do not let blood, semen or vaginal secretions get on each others' mucous membranes.

- HIV in semen is most easily spread to other people during vaginal and anal intercourse. If latex condoms ("rubbers," "love gloves") are used properly, they can significantly reduce the risk of HIV transmission during intercourse.

It is very important to use condoms from "start to finish." Penetration, even without ejaculation, can spread HIV, because the virus lives in both vaginal secretions and in pre-ejaculate.

If you haven't used condoms before, or feel curious or uncomfortable about them, you may want to practice with them in a nonthreatening situation. Use nonlubricated condoms to practice putting them on and taking them off objects such as bananas. Men may want to put condoms on themselves while masturbating to learn how to use them.

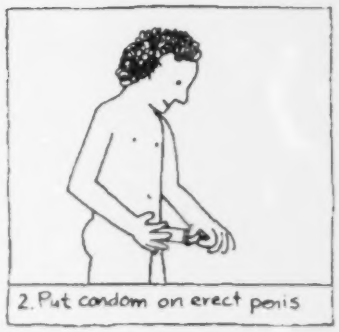
Step-by-step instructions on how to use latex condoms correctly

First, remove the latex condom from its packet. Don't tear the condom.

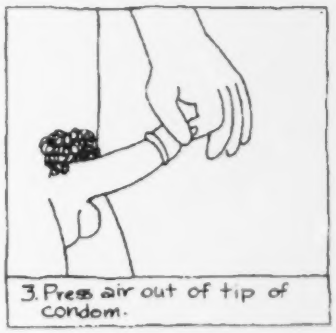
The penis needs to be erect (or fairly erect) before the condom is put on.

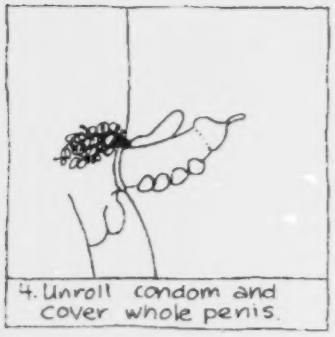
You can place a small amount of water-soluble lubricant in the tip of the condom. This will increase comfort and sensation. If the lubricant contains nonoxynol-9, it also kills both sperm and HIV.

Uncircumcised men should pull back the foreskin of the penis before putting on the condom.



If the condom has a reservoir end, squeeze out the air as you put it on the penis, because air bubbles could cause the condom to break. If the condom doesn't have a reservoir end, unroll about half an inch of it so there will be room for the semen; squeeze the air out.





Unroll the condom down the length of the penis. If it's on upside-down, it won't unroll. Start again. It's best to start over with a new condom because the upside-down one may have pre-ejaculate on it which can contain HIV.

A water-based lubricant such as K-Y Jelly should be used on the outside of the condom to reduce likelihood of irritation, cuts, or tears to the vagina or rectum. Water-based lubricants provide more wetness, increase feeling and sensation, and help keep condoms from breaking. Spermicides containing nonoxynol-9 kill HIV as well as sperm. Lubricants containing nonoxynol-9 can sometimes be irritating to mucous membranes. If you find that nonoxynol-9 makes you uncomfortable during vaginal intercourse, use a plain water-based lubricant with the condom. Don't give up on latex condoms. Nonoxynol-9 spermicides should not be used as lubricants during oral or anal intercourse. Research has not yet shown that nonoxynol-9 is safe for use during pregnancy. Oil-based lubricants such as vaseline, cold cream, cooking oil, or hand lotion should not be used because they make the latex condom weaker. Drugstores sell water-based lubricants, such as K-Y Jelly, along with condoms.

Feel to make sure that the condom stays in place during intercourse.

After ejaculation, while the penis is still firm, hold the rim of the condom around the shaft of the penis and withdraw.

Then slip the condom off the penis, without spilling the ejaculate.

Tie the end of condom and throw it away. Don't flush it down the toilet—condoms plug plumbing, septic systems and municipal sewage treatment systems!

If you have intercourse again, use a new condom. Never reuse a condom.

It's best to store condoms in cool, dark places. Warm places (such as the glove compartment of a car or a hip pocket) may weaken the latex.

Although condoms aren't 100 percent effective, they are very effective when used carefully and consistently. Using them correctly keeps condoms from breaking or slipping off.

- "Female condoms" (intravaginal pouches) are now being manufactured. They are like a latex sleeve that fits inside the vagina and is held in place over the cervix like a diaphragm. There is also a ring on the outside of the vagina that holds the condom in place over the vulva. They work as a barrier to HIV just like the condoms for men.
- Don't let pre-ejaculate and semen get into the mouth during oral sex. Either use a nonlubricated condom or avoid putting the tip of the penis inside the mouth.
- Women considering artificial insemination should be sure that the sperm bank they use tests donors for HIV.

If you are having intercourse, the best safety precaution is using a latex condom correctly. Other birth control methods such as IUDs and birth control pills do not reduce the risk of HIV transmission. Withdrawal of the penis before ejaculation doesn't prevent exposure to pre-ejaculate or to vaginal secretions, which may contain HIV.

Safety skills for preventing exposure to vaginal secretions and menstrual blood.

- Use condoms as described above to provide a barrier between the penis and vaginal secretions or menstrual blood which may contain HIV.
- Vibrators or dildoes should be carefully washed with soap and water if they are used by more than one person.
- Dental dams or condoms that have been cut open to form a rectangle of latex may be used as a barrier between vaginal secretions or menstrual blood and a partner's mouth during oral sex.

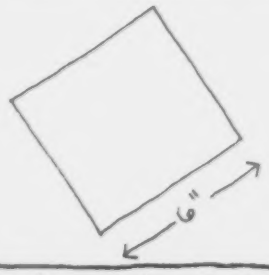
HIV and other organisms can enter the mouth and cause infection and illness when a person has oral contact with a woman's genitals or with the anal area. Because latex gloves and latex condoms are proven barriers to infection, people deduce that a latex barrier placed between the mouth and a woman's genitals or a person's anus can prevent HIV or other organisms from entering the mouth. To be effective, the latex barrier must not have holes or tears in it. It is also important that it not get turned over accidentally.

In areas where it is difficult to purchase dental dams, people make latex barriers by cutting open latex condoms. A benefit of using condoms to make flat latex barriers is that the quality of condoms must be carefully checked by manufacturers.

1

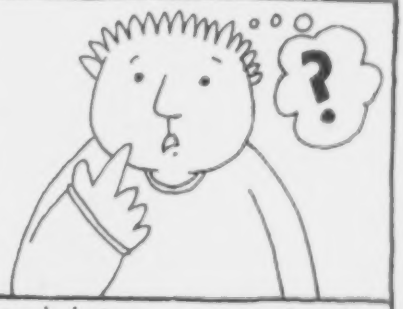
Latex barriers may be used during oral-vaginal or oral-anal sex. They reduce risk of HIV infection because they keep vaginal secretions or blood from entering the mouth.

2



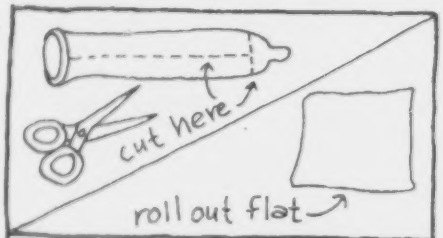
Sometimes, latex dental dams are used as latex barriers. They are flat pieces of latex about six inches square.

3



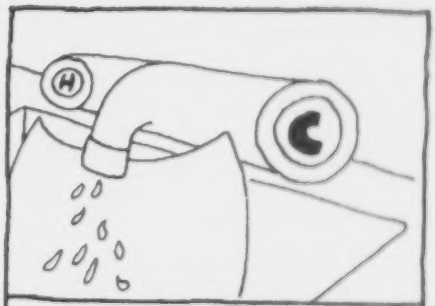
Dental dams may be hard to find. They are sold through dental supply houses.

4



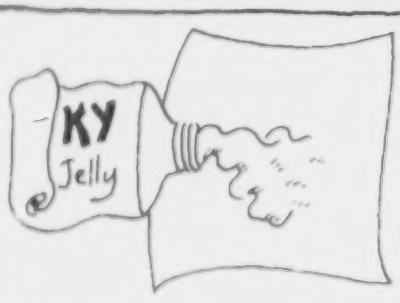
You can "cut down" a non-lubricated latex condom to make a latex dam. Don't use Saran wrap or plastic wrap. Some plastic wraps have pores that will allow viruses to pass through.

5

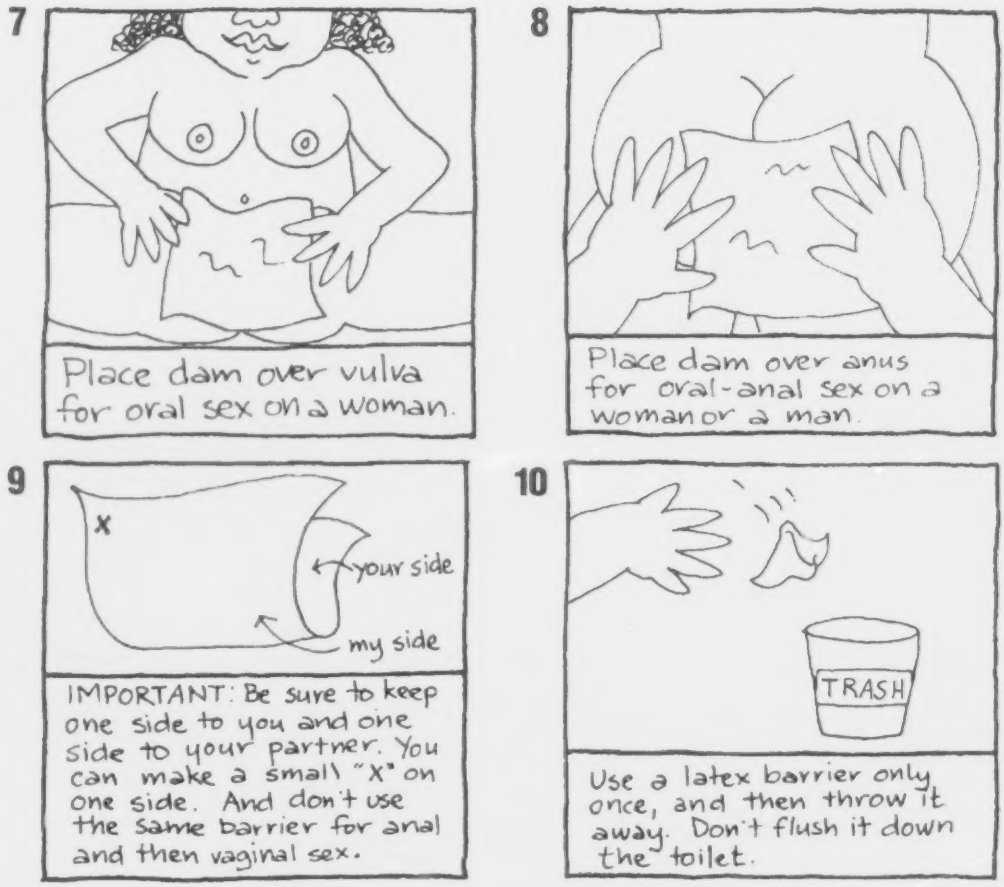


Suggestion: A dental dam can be rinsed in cold water before use to wash off the cornstarch powder.

6



You can use a water-based lubricant on the vulva or anus side of the dam.


7
Place dam over vulva for oral sex on a woman.
8
Place dam over anus for oral-anal sex on a woman or a man.
9
X
your side
my side
IMPORTANT: Be sure to keep one side to you and one side to your partner. You can make a small "X" on one side. And don't use the same barrier for anal and then vaginal sex.
10
TRASH
Use a latex barrier only once, and then throw it away. Don't flush it down the toilet.

So far there have been no clinical studies to test the effectiveness of dental dams in reducing the risk of HIV transmission.

Situations that may block risk-reduction efforts.

- Drug and alcohol use don't cause HIV infection, but people who are drunk or high may not make careful choices about sexual partners or activities. Also, addictive drugs, such as "crack," even though they are not injected, may put users in situations where unsafe sex is traded for drugs.

• Situations in which one partner has less power than another partner may increase risk of unsafe behavior. For example, date or acquaintance rape is a very common occurrence. If someone is denied the choice of whether or not to have intercourse, it is difficult for them to insist on condom use.

• If physical or psychological abuse happens in a relationship, the abused partner may have little power to insist on safer sex. Some partners may feel that bringing up AIDS, HIV transmission, or safer sex may lead to abuse. The threat of immediate physical injury may seem much worse than the threat of eventual illness from HIV infection.

• Age differences in sexual relationships may place the younger partner at a power disadvantage.

• Many HIV/AIDS educators are troubled that women are often made responsible for initiating safer sex or condom usage. Women frequently are in less powerful positions within their relationships—they may lack economic resources and access to support systems, for example. A woman may feel that the man she loves will leave if she raises the issue of safer sex or if she questions drug use. AIDS education must also address the power imbalances that women face. Risk-reduction efforts must address heterosexual men's responsibility for initiating safer sex and proper condom use.

Power imbalances of many kinds can block prevention practices in sexual relationships. Power imbalances can occur in heterosexual and gay, newly established or long-term, monogamous or nonmonogamous relationships.

Community support

Stopping the HIV epidemic will demand hard work from all of us. People need to learn and understand risk-reduction skills. People need to communicate with potential needle-sharing or sexual partners so that they will not risk spreading HIV through unsafe activities. Safety measures such as condom use, the availability of needle cleaning kits or sterile needles, and the practice of universal precautions by health care workers need to become as common and automatic as wearing a seatbelt. Communities need to support their members who are making risk-reducing choices, such as abstaining from sexual intercourse, insisting on condom use during intercourse, or refusing to share dirty needles. Stopping the epidemic will involve talking about a lot of topics that people have viewed as off limits. Communities need to risk these life-saving discussions!

CHAPTER 2

How to Talk to Kids about AIDS

Why talk to kids about AIDS?

Children and young persons are concerned about AIDS. It is a major element of the world that they are inheriting. It will potentially transform their views on sexuality, health, life, and death. It may transform their communities. It may have a direct impact on their families and loved ones. Young people are hungry to understand more about this disease and to learn ways they can live well and fully in a world where AIDS is a possibility.

Further, kids are at risk for HIV transmission. Surveys demonstrate that the large majority of Americans engage in sexual intercourse while in their teens.

This is true of all kinds of kids, including inner city, rural, suburban, and from a wide variety of cultures and religions.

The majority of these kids do not use condoms consistently when they have intercourse. Rising rates of unplanned pregnancy and of sexually transmitted diseases such as syphilis and gonorrhea among teens document the real and potential risk of HIV infection to sexually active youth. If HIV is present in a sexually active teen population today, it is spreading. To make this risk very graphic: Any young woman who has become pregnant also potentially was at risk of HIV infection.

A significant number of young persons use injectable drugs and may share needles. Needle-sharing during the injection of psychoactive drugs, steroids, or insulin can transmit HIV. Tattooing and ear-piercing may also involve shared needles.

An additional dimension of risk for HIV infection faced by young people comes from common misinformation and confusing information they may receive about AIDS and HIV. One type of confusion they may experience comes from discussions about risk groups rather than risky activities. Teens, in particular, are in the process of developing their own unique sense of self. The practice of labeling some persons (gay men/"faggots," IV drug users/"junkies," people who "sleep around") as especially at risk for AIDS may put teens at risk. Kids usually view persons with labels such as these as "somebody else."

Labels themselves may be threatening to a young person's developing sense of identity. A young man who has male lovers may not view himself as "gay." A young woman on her third long-term (six month) steady relationship may view herself and her partner as "monogamous." An eighth grader who "skin pops" drugs knows "IV drug user" means someone else. For kids to understand their real risk of HIV infection, they must be told directly that they are at risk. Saying that AIDS mostly affects members of high risk groups may offer teens an easy out when it comes to personal risk assessment. It may make AIDS into "someone else's disease," and leave the young person still willing to act in ways that might transmit HIV.

While educational campaigns among gay and bisexual men have resulted in reduced sexual transmission of HIV and dropping rates of other sexually transmitted diseases, campaigns addressed to young persons have not yet succeeded. Parents and other adults in close day-to-day contact with young people may be in the best position to understand young people's concerns and risks for HIV infection, and may be the most effective teachers of personal risk assessment and HIV prevention skills.

The final reason for encouraging adults to teach young people about AIDS is a very hopeful one. When information is presented in the right manner at the right time, at a teachable moment, young people are often enthusiastic learners. They can adapt to new information. They can change their activities and reduce their risk for HIV infection.

It is vital that young people get direct, specific information about activities that could put them at risk for HIV infection. We hope this book will help you to learn to understand the age-specific learning abilities of children, the risk reduction skills children may need, and techniques for helping children to learn these skills.

Helping kids to keep safe

All of us, and particularly young people, look for acceptance from others. Keeping safe from HIV infection depends on a combination of accurate knowledge and motivation to put that knowledge to work. For a young person, as for anyone, feelings of self-worth and acceptance may form the foundation he or she needs to practice HIV safety skills.

Some children and young persons already face risks for HIV infection. These risks may be different for different age-groups of children. They may include

- Being born to a mother who had HIV.
- Being breastfed by a woman with HIV infection.
- Receiving a blood transfusion containing HIV.

- Receiving clotting factor containing HIV.
- Being sexually abused or raped.
- Sharing needles used for legal or illegal drug injections.
- Sharing needles for tattooing or ear-piercing.
- Having vaginal, anal, or oral sexual intercourse.

For most children and young adults, HIV infection is a risk to be avoided someday in the future. You can work with them to build skills and values that will encourage them to keep safe. You can help them to understand facts that will reduce their risk of ever becoming infected with HIV. You can accomplish a wide range of other things by talking about HIV/AIDS with young people. Depending on their ages, their questions and concerns, and your style of communication, you may

- provide information and answer the child's questions;
- calm unrealistic fears the child may have and let them know that prevention works;
- open the lines of communication with the child in new ways, because of the special challenges and range of issues each of you face in talking about AIDS together;
- earn more about the special person the child is and share more of your own values and approaches to life with the child; and
- teach the child about the marvels and intricacies of the human body and how it functions in health and disease.

Further, you, as a caring adult, can help young people to assess and understand any risk they may have of HIV infection. Depending on your role within a young person's life, you can help her or him to determine how to cope and what risk-reducing action to take. In some situations, your role may be to provide young people with information about safer behaviors and to encourage them to start to practice them. Talking about condoms and safer sex with a teenager who is considering or already having sexual intercourse is an example. You can stress that the responsibility for safer sex practices belongs to both partners and that safer sex should *always* be practiced with all sexual partners. In other situations, your role might be to act directly to protect the child. An example of this would be reporting a case of sexual abuse.

This chapter will present some ideas that may help you in talking with children and young people about HIV/AIDS.

Building a foundation for HIV safety

The foundation you can build to help your child avoid HIV infection includes getting into the habit of communicating with the child, developing the child's respect for the human body, building the child's understanding of human sexuality, showing that you understand and practice HIV-prevention skills, and supporting the child's self-esteem. Building a broad foundation of positive communication skills and HIV awareness will help whenever you have specific talks about HIV/AIDS and many other topics.

Foundation Building Block Number One: Communicating positively

Effective communication is important as a tool for teaching children to reduce their risk of HIV infection. Effective communication depends on your ability to listen carefully, to understand where your child is and what his or her concerns are, and to speak what is on your mind. There are some basic guidelines for communicating effectively that can help when it comes to talking about AIDS.

- Be clear. Use specific language (say "oral, vaginal, or anal intercourse" instead of "sex" or "sexual contact").

- Answer young people's questions, then ask them to tell you the answer. That way, you can make sure they understood what you said. If they didn't understand some areas, you can explain again and clarify their knowledge.

- If you're confused, say you're confused. Maybe you can work together to find the answer you need.

- Find a good, private place to talk with your child that is comfortable for both of you. AIDS is a tense topic, so do what you can to keep both of you relaxed.

- Above all, listen to your child. The less you talk the more you may learn. Listen for the meaning behind the questions they ask. You need to understand what they are concerned about before you can address their questions. Too often young people accuse adults of not listening; too often they are right. Listening includes watching for nonverbal cues and asking for clarification when you don't quite understand. It means quieting down that part of our brains that always debates with the person who is speaking. Really listening is one way to show young people that you care.

- Recognize the sensitive nature of children's feelings and fears. Foster a climate in which all questions receive respectful answers regardless of how sensitive the issue.

• Try using "I" statements instead of "you" statements. For example, say "I feel worried when I hear that some of your friends drink and drive. I'd like to talk about this so that we make sure you can keep safe." instead of, "You always hang out with kids who take too many risks." This may help you to get your message and values across to your child in a context that facilitates discussion, sharing, problem-solving and mutual respect.

One easy way to remember key elements in talking with young people about AIDS is this. The letters A-I-D-S stand for more than Acquired Immune Deficiency Syndrome. When you're thinking about talking with kids about AIDS:

A stands for Appropriate Time—a planned talk or a teachable moment.

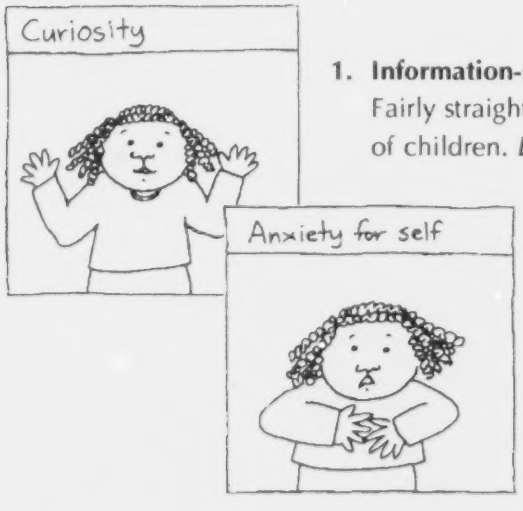
I stands for Information. When you're not sure of the facts, it can stand for "I don't know. I'll help you find out."

D stands for Discussion—talking to and really listening to your child.

S stands for Supporting your child's self-esteem!

Kinds of questions*

When children ask questions about AIDS, it is important to understand the meaning behind the question that is being asked:



1. **Information-seeking and general curiosity**
   Fairly straightforward questions based on the natural curiosity of children. *Example:* How do people get AIDS?

2. **Anxiety for one's own welfare**
   Questions based on anxiety with the intent of finding out if they are at risk themselves. *Example:* Can you get AIDS from kissing?

*Adapted from *Does AIDS Hurt? Educating Young Children about AIDS*, by M. Quackenbush and S. Villarreal, Santa Cruz, Calif.: ETR Associates, pp. 17–19. 1988/1992.

3. **Anxiety for the welfare of parents, siblings or other family, and friends.**
   Questions, sometimes quite direct, based on knowledge about adult behaviors that kids know may be connected to HIV infection. *Example:* Is it okay for my daddy to have sex?

4. **Solution-seeking**
   Based on kids trying to come up with solutions to a "fatal disease."
   Example: Can we give somebody with AIDS new blood?

5. **Seeking reactions from adults**
   Based on children's sensitivity to adult feeling about AIDS, these type of questions are asked to see how the adult will handle a difficult or embarrassing question. Answer calmly, factually, in an honest, matter-of-fact style.
   Example: Did you and Daddy have sex before you were married?

6. **Special psychological needs**
   Intense preoccupation of a child with any topic, including AIDS. If excessive concern persists, seek counseling.
   Example: Without any apparent reason your son has been asking questions about AIDS three or four times a day for over a month.

Guide to answering questions

1. **Try to understand the meaning behind the question.** See above.

2. **Answer it now, rather than later.**
   Example: Your child interrupts you while you are watching your favorite television program with a question about AIDS. Answer the question. Don't say, "Not now, I'm busy."

3. **Answer calmly, in matter-of-fact manner.**
   Example: Your child says in an accusatory tone, "You're going to get AIDS if you keep going to all those meetings on sex." You answer the concerns calmly and directly by explaining that you can't get AIDS by talking with people or going to meetings. You may want to explain (again) how AIDS is transmitted. You also may address the real problem of attending a lot of meetings lately.

4. **Admit it if you do not know the answer to a question.**
   Example: Your child asks you where HIV came from. You admit that you don't know. You look it up the next day and find out that nobody else knows for certain either.

5. **Find out new facts and get back to the child with an answer later.**
   Example: The next evening you report back to your child that there are lots of ideas about where HIV came from, but none of the ideas has been proven yet.

6. **Answer questions in a way that is appropriate to the age and sophistication level of the child.**
   Example: Your kindergartner asks you, "What's AIDS?" You tell him it is a serious disease that some people get. You add that it is a hard disease to get, so he doesn't have to worry about getting AIDS.

7. **Answer questions honestly and concisely.**
   Example: Your child asks you if a family member, Uncle Dan, has AIDS. You say, that Uncle Dan has an infection that leads to AIDS in many people. You can also say that you don't know yet whether Uncle Dan will get AIDS. Right now he is healthy and the doctors are giving him medicine to keep him healthy.

8. **Check to see if the child understands the answer.**
   Ask the child to answer a question for you to check his understanding of the information.
   Example: "Now you can tell me, does Uncle Dan have AIDS?" If the child can tell you the information in her own words, she has probably understood what you said.

Foundation Building Block Number Two: Sexuality is more than AIDS

Before young people can make decisions about HIV prevention, they need to have a basic knowledge and understanding of sexuality. Sexuality is an integral part of each person. The way in which young people accept themselves as sexual beings will influence their sexual decision-making.

Parents need to acknowledge sexuality as a healthy, positive part of life. HIV prevention can be viewed as one aspect of maintaining a healthful sexual life. You can show children how to ask questions, express feelings, gather information, and change what they do by sharing how you ask questions, express feelings, gather information and change what you do. You can teach children by talking with them about their questions, feelings, and choices and by being a role model for them.

Beyond the Birds and Bees*

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Helping parents discuss sex with young children

"Mommy!" a piercing voice echoes through the crowded supermarket. "Look at that lady? Why is her tummy so fat?"

Although these questions do not always arise in supermarkets, young children do not restrict their curiosity about any aspect of human life or sexuality to the privacy of their homes. All too often parents who want to do a good job of answering their children's questions are caught off guard by a child who does not realize that parents find some subjects easier to discuss in non-public places. Even when a parent attempts to answer the initial question on the spot, children may persist:

*Reprinted from 321 HDFS 8 (1985), a fact sheet in the series "Resources for Parents and Others Who Care about Children," Cornell Cooperative Extension.

"Mommy! Why is that lady's tummy so fat?"

"She has a little baby growing in her uterus."

"Why?" asks the insistent (and loud!) voice.

"I guess she thought it would be nice to have a baby to love and take care of."

"How will it get out of her?"

At this point most parents give up on the marketing and remove the child to the car, where they try to explain that babies are born through a special opening between the mother's legs called a vagina.

"Does it hurt the mommy?" the small questioner wants to know.

"Sometimes it hurts, but there is always a doctor or a daddy or a good friend with the mother who knows how to help her and the baby. And having a new baby is so exciting that most mothers almost forget about the pain when they see a new little daughter or son." By now the parent is beginning to feel more comfortable as she recalls previously rehearsed words and phrases. The child, however, is ready to move on to other issues. Questions such as "Can we stop at McDonald's?" or "Why do caterpillars go up in bumps when they crawl?" indicate that human sexuality is an interesting topic, but perhaps no more absorbing than many of the other practical and scientific aspects of life. The questions about babies and birth will come back again, and yet again, as the child grows older, absorbs information, and fits it into an ever-changing understanding of how the world works. As the child grows, parents expand their responses to questions, adapting their information and values to the ability of the child to understand and accept an increasingly mature view of sexuality. The following principles may provide some useful guidelines:

- There is no "one way" to discuss sex with children; there is especially no single "right" way. Even within the same family, parents will find themselves changing explanations and discussions to meet the special characteristics of individual children.
- Many parents feel inadequate as sex educators and wish that the school or a book, as an "expert," could do the job instead. It is the opinion of many professionals who work with families, however, that parents—even when they stammer, blush, and blunder—are uniquely qualified to respond sensitively to their children.

Children themselves often help their parents over rough spots in communicating about major issues, including human sexuality. Parents who say to their children, "I find it hard to explain this but let's give it a try," or "When I was little we couldn't talk about things like sex, but I really want to learn to talk with you about it," often find their children to be warm and sympathetic listeners, as well as skilled, insistent questioners. The essential characteristic of

parents who want to be the primary sex educators of their children seems to be a willingness to try to communicate. How and what we say as parents is probably much less important than remaining open to, and unshocked, by the questions and comments of our children.

- An important beginning can be made by parents who take time to listen carefully to the question. Most of us have enjoyed the story of the little girl who inquired, "Where did I come from?" and received from her mother a lengthy explanation of conception and birth ending with the question, "Now do you think you understand?" "No," said the child, "Susie comes from Buffalo, and Bobby comes from New York, but I still don't know where I came from!" Short, simple answers specifically directed to the question can avoid this kind of confusion!
- Young children's curiosity about human bodies and body functions is as matter-of-fact as their curiosity about anything else. Parents can provide factual answers to questions from very young children, reserving a discussion of ethics and morality until children are old enough to understand. Although parents are sometimes surprised when young children think that sexual behavior is funny, this reaction is not uncommon among children.
- Some of the common behaviors parents worry about in young children include masturbation, examining themselves and the bodies of their friends, preferring to be nude rather than dressed, and using sexual language in their play. Unless these behaviors are extreme, in that they occupy most of a child's waking hours, they should not be regarded as "problems."

Children acquire information about and attitudes toward sex whether or not their parents intend for them to do so. Friends, magazines, television, and the attitudes, conversation, and behaviors of adults they observe have a great influence on a child's emerging concept of sexuality. Parents can choose to provide their children with accurate information presented with respect and dignity, or they can allow their children to pick up the information and the misinformation that is all too widely available. It would be difficult indeed for any parent to prevent comments and impressions about sexual behavior from reaching a child in an American community. And it would be even more difficult to insure that healthy attitudes will occur without direct parental guidance and support.

Answering direct questions is only one of the ways in which parents impart information about sexuality to their children. Basic feelings of respect for the human body and an understanding of body functions may begin in infancy as a result of the gentle care and accepting attitudes of those who care for the baby. During the early years, children learn labels for parts of the human body, usually checking their own bodies and often those of other people who have breasts, or a penis, or other attributes indicating differences between male and female, child and adult. Many women have experienced a toddler's casual exploration of their breasts, and many men have been accompanied to the toilet by curious babies anxious to watch again the wonderful way in which males urinate.

Often the process of learning about human bodies includes doctor games in which one child is the patient and another is the examiner who pays particular attention to the patient's genitalia. Parents who discover such a game in progress often wonder how to react. "I don't want to make them feel guilty or bad because I know they're not really doing anything wrong, but I really don't want them to do that," seems to be a fairly common parental reaction. We would suggest that while it may be bewildering to a child if the parent exhibits shock, anger, or fear, it is appropriate for parents to react honestly, as for example, "I'd rather you kept your clothes on when you play together," or "People's bodies are private. We can find some books at the library and you can see how people are made by looking at the pictures," or "I want you to play something else—I don't feel comfortable about this game."

Parents who feel comfortable with the doctor game need not comment or interrupt except to insure that children will not hurt each other (as, for example, "giving shots" with sharp objects or introducing foreign objects into a body opening). Usually when the children's curiosity is satisfied they move on to other activities. Adult fears that information about sex will lead children to experiment with sexual activities do not seem to be borne out in real-life situations.

Other issues related to a child's understanding of human sexuality during the early years also raise questions in the minds of many parents. Sometimes a child encounters evidence of a mother's menstruation - tampons stored in an accessible place, for example, or stains on clothing. Some parents feel it is most appropriate to ignore or evade their child's questions. "That (tampon) is just something of mine. Please put it back where you found it," or "I guess I cut my finger and wiped it on the back of my skirt." These responses are often made by parents who feel preschoolers cannot or should not understand menstruation. Other parents report that they have tried some simple explanations that their children seem to understand and accept. For example, "That's called a tampon. Older girls and women put the soft little pad inside their vaginas when they menstruate." Sometimes, rather to the parent's surprise, children will say "Oh" and go off about their business. Sometimes a child will ask, "What's menstruate?" One mother answered, "Menstruation is the way a woman's body keeps a special place inside her uterus ready for a baby to grow. Every month a little bit of blood leaves her body through her vagina. It doesn't hurt her because it's not a bump or a cut. The blood carries away the old lining of the uterus. Each month a new lining starts to grow so that her uterus is always ready for a baby should one start to grow." Other parents have used part of this explanation, feeling that their children were not ready for it all.

One great benefit of a simple explanation of menstruation at an early age is that these children are usually very matter-of-fact and unsurprised, whereas an eight- or nine-year-old who has never discussed it before may become difficult to talk with, giggly, or embarrassed. It would seem important for both parents to be informed about any explanation that has been given to a

child so that clarification can follow if their child seems confused. Parents should also decide whether or not boys as well as girls should be included in any discussion of menstruation.

Evidence increasingly suggests that masturbation is engaged in by many healthy and mature adults. Babies delight in the discovery of their undiapered genitalia. Older babies examine their own bodies with great care and interest and soon find the sensitive areas that feel good when touched or rubbed. By two, many children have developed particular ways of acquiring pleasant physical sensations. Some rock back and forth on a pillow between their legs, or spend a good deal of time on a rocking horse, or fondle their genitalia before sleeping, or otherwise indicate that people learn early to obtain comfort and pleasure through self-stimulation. Parental attitudes toward these behaviors can influence children's feelings about themselves either as good people worthy of self-respect or as people who do "bad" and "dirty" things about which they should feel guilty and ashamed. Although parents should not attempt to use any childrearing principle or technique that is at variance with their religious and moral standards, I believe young children are fortunate when they experience acceptance and understanding as they explore and fondle all parts of their bodies.

Even the most understanding parents, however, should not tolerate behavior that is embarrassing to them or other people. It would be appropriate for a parent to say privately to a child who is openly masturbating in the middle of the living room or in front of guests, "I know that touching yourself in that special way makes you feel good, but that's something people do in private. You can find a private place in your room." One mother recalled an episode with her three-year-old daughter and two-year-old son as they rode along the aisles in the supermarket cart. As they progressed past the vegetables she heard Betsy say, in loud and reproving tones, "Bobby, you know you're not 'sposed to hold your penis in public—wait 'til we get home to do that."

Young children have earned their reputation as the world's greatest imitators. If they see a machine, an animal, or a person participating in an interesting activity or making an interesting sound, they are quite likely to imitate in their play what they have seen or heard. Children may imitate adults they have seen or heard engaging in sexual activities or using sexual terms in their conversation, but this does not mean they have precocious sexual interests or will become deviant—or even "morally loose." It means that they are testing out new information and experiences, as they test out other phenomena they observe. Through play, children try to achieve a sense of mastery and accomplishment, which enables them to move on to other experiences and issues.

Often children raise questions about components of human sexuality that are difficult to answer. When this happens, the parents' intimate knowledge of the child, their understanding of

the child's learning style, and their basic commitment to honest communication—even when it's hard—will usually help them deal sensitively with the questions. In a recent parent meeting, one mother reported that her four-year-old son had asked her what an abortion was. Other parents indicated that a television show had raised the same question among their children. Another parent told the group that her daughter had seen two men kissing each other on the street and had been told by a teenaged friend that they were "gay." The group agreed that children are encountering more varied and more puzzling human behaviors than previous generations and that the job of being a parent becomes more challenging with every new question.

Sometimes additional challenges seem to arise as children grow older. For example, parents of children approaching puberty often voice concern over the fact that feelings and experiences the family had earlier discussed openly and frankly are now no longer mentioned at all. The children who had accepted their own bodies and, perhaps, the nude bodies of family and friends, now begin to demand privacy. Bedroom and bathroom doors are firmly shut, and parents may even find themselves excluded from dressing rooms while shopping for a child's new clothes. Efforts by parents to talk about body changes or reproduction or love—or any other "embarrassing" topic—may be met with "Oh Dad-dee" or, what may seem worse, silence or withdrawal. When this happens parents may feel guilty, wonder what they did wrong, and try desperately to reestablish verbal communication about important issues with their child. At the very least, parents who feel they had been able to talk with a child at an earlier age feel disappointed. Sometimes parents feel afraid as they wonder what will happen during adolescence if they and their child "can't talk" now.

The fact that teenagers may not be verbally communicative with parents about sexual issues does not necessarily mean that parents have failed in their efforts to communicate. The teenager has not forgotten the discussions engaged in with parents in the past. The information and attitudes received from parents may be being tested and tailored to fit the needs of an adolescent struggling to become an adult. Attitudes and values continue to be conveyed through the ways in which parents listen (or fail to listen) and respond to the feelings and behavior of others and exhibit feelings and behavior themselves. Children continue to need strong, loving support and sound information from parents during their teens. The challenge is to provide that support in ways that may be more subtle and more varied than those used previously.

In addition to hoping that their children have developed attitudes of liking and respect toward their own bodies, most parents hope also that their children will be able to respect the morality of others whose views may be different from their own. And, perhaps, because memories of their own teen years are still vivid, parents understand too well the adolescent need to behave in ways that are acceptable to one's peers.

It may be reassuring to know that several careful studies of adolescents in America indicate that some of the impressions we have received from public media about teenagers may be misleading. The teen years, while difficult, are not necessarily more difficult than other life stages. Also, most teenagers feel that their families are important to them and that the attitudes and values of their parents continue to influence them. A child entering adolescence does not suddenly become a different person, cut loose from parents. While some adolescents are troublesome, or troubled, or experimenting with activities that are unacceptable to adults, many deal with the pressures of growing up according to standards quite similar to those of their parents.

All of us hope our children will develop a sense of basic and enduring decency. Most of us hope also that our children will grow up proud of their own healthy bodies, respectful of the bodies and feelings of others, and able to move into a joyful sexual relationship with another loving adult. The attitudes, behavior, and expressed values of their parents have a profound effect on children. Adults who have felt inhibited, guilty, or ashamed of their own sexual inadequacies have often struggled hard and managed to communicate successfully with their children. These adults, who may also understand the value of sex education programs in schools, churches, and community groups, acknowledge their responsibility as the primary sex educators of their children. They are among the many parents who acknowledge that communicating with their children about human sexuality can be funny, scary, hard, bewildering, illuminating, fun—and very important.

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Foundation Building Block Number Three: Modeling HIV safety

Parents and caring adults make up an important part of young people's world. They provide the norms of behavior that young people experience during their formative years. In a time when risk of HIV infection is a reality, it is very important that the norms adults provide to young people include ways of keeping from becoming infected with HIV. Since HIV is a new concern, this may mean that the norms adults live by need to change before they are safe norms to teach to young people. This may feel frightening in many ways. Yet it is probably less frightening to deal with making these necessary changes than it is to deal with being infected with HIV.

One fundamental change for most parents is that they need to establish a climate for talking about all kinds of life issues including sex. Talking about HIV prevention means talking about intimate sexual practices in detail. If the groundwork has been laid for such discussions early on, it will be much easier to introduce new information as the child matures or the need arises.

Foundation Building Block Number Four: Supporting self-esteem

Parents and caring adults also contribute to young people's feelings of self-worth and competence. Sometimes *how* something is said is at least as important as *what* is said. A conversation that makes a young person feel loved and accepted at the same time as offering them information may work better than a lecture containing the same information. This is very true in talking with young people about AIDS and HIV. It is also sometimes very challenging. Don't forget that your reason for having these conversations with young people is because you love them and care about their health and safety.

Young people need to feel acceptance from adults. One of the things that makes peer pressure so powerful is the acceptance that people feel when they go along with it. Peer pressure works when a group only values some ways of looking, talking, or doing things, and people want to feel accepted by that group. So they change how they look, talk, or act. Then they feel accepted by the group and good about themselves.

One of the challenges of communicating with young people about AIDS is learning how to do it in ways that young people feel consistently valued and accepted. It is critical that the conversations include positive discussions about issues of sexuality rather than being centered upon sexually transmitted diseases with a "no," "don't" focus. A child will feel as though they are treated with respect and more as an equal if the adult talks frankly to them about a wide range of topics, not just problems. This usually helps to keep the lines of communication open. It may mean reinforcing young people's feelings of self-worth by listening to what they share and showing that you value their willingness to share it. It may mean "catching them doing something right" and telling them about it. It may mean praising them for the questions they are asking about AIDS and HIV and helping them to solve very real risk-reduction problems. Sometimes your willingness just to listen to young people talk will make them feel accepted and valued. Just listening can be difficult, especially if a young person may be talking about taking risks, but it is worth it for the trust that it builds.

Foundation Building Block Number Five: Recognizing young people's fears

Because young people understand that AIDS is a part of the world they are inheriting, they may feel a great deal of concern or fear about HIV infection. They may worry that they will become infected or that someone they love will have the virus and get sick. Talking with you will help them to cope with a world where AIDS is a reality. The information you give them may help to relieve their feelings of fear. AIDS can be prevented through education and action.

Conversations with kids about HIV/AIDS

Any conversation about sex or drug use or disease may feel uncomfortable at the beginning, because these are topics that are rarely discussed between adults and young people in our society. Many adults don't even talk about these topics with other adults! Sometimes adults hide behind factual information when dealing with controversial subjects. Facts are important, but they are impersonal. Facts alone are not likely to change someone's behavior or to form the sole basis for their future decisions. Research has shown that young people who know all the right answers about AIDS still do risky things. To be effective, education must address both the factual and emotional aspects of charged issues such as AIDS.

Remember that you can have many types of conversations about AIDS with young people. Some may mostly involve listening, some may involve sharing feelings and discussing facts, some may focus on information you are passing on to your child, and some may focus on solving problems and planning what you or your child will do. All of these types of conversations are very important, even if each has a different style. It is also possible to have your child leave each type of conversation feeling accepted, valued, and supported in learning how to cope in a world with AIDS.

Once you have learned some basic facts about AIDS and ways of reducing the spread of HIV, you are ready to talk with your child. Make sure that you and your child both have an understanding of the clinical and slang words each of you uses to discuss sex and drugs. It may help if you teach children the correct terms for all their body parts in a matter-of-fact way when they are young. Parents can tell infants and toddlers, "This is your hand, this is your knee, this is your vulva/penis, this is your foot, this is your nose." This will build the young child's sense of comfort and respect for the human body. It will help to build the foundation needed for talking about sexuality later on.

Two common situations in which you may talk with your child about AIDS are 1) when you have made a special plan to have a conversation about AIDS, and 2) when a special opportunity for talking with your child about AIDS just happens. The building blocks for either talk are the same.

Conversation Building Block Number One: Know your child

First, you need to think about your child: age, questions or concerns about HIV, what information your child already has about AIDS, where the information came from, and whether that information is correct. You need to think about any special circumstances your child might face in terms of AIDS: Does your child know or love anyone who has HIV? Is a child with HIV enrolled in the school? If your child has hemophilia, does he or she feel afraid or face stigma related to AIDS? Is your child sexually active? Does your child fear that you may be at risk? Also, think about times and situations when you and your child have had good talks. What went into making those talks comfortable and effective?

Conversation Building Block Number Two: Accurate HIV/AIDS information

Next, think about the information you know about AIDS and HIV. Do you need to know more to feel secure in presenting the information? What pieces of this information does your child need to know now? Some information might resolve unrealistic fears your child may have about AIDS. Other information might be important for your child to have to change risks he or she may be taking. Your child may be too young to understand some of what you know about AIDS, so think about what information you can save to teach your child later on. Does your child have a grasp of the vocabulary and concepts that will enable her or him to understand the information you wish to present? Make a plan of what you want to say.

Conversation Building Block Number Three: What are your values?

Third, think about your beliefs and values in relation to the information you want to share. Examine your values and try to determine where they have come from. Make a plan for what values you want to teach your child. Be aware of the impact of your values on the information you tell your child about AIDS. Do you have personal difficulties with any issues related to AIDS? Try to present a balanced point of view and admit that some of the topics are controversial and hotly debated. Sometimes it may be difficult to talk with your child about something very important, because you fear finding out that your child is doing something that goes against your values. For example, I may feel very strongly that shooting cocaine is wrong—so I avoid frank conversations about drug use with my teenager. I may disapprove of premarital sex—so I avoid talking with my sexually active son about condom use. I may feel that vaginal intercourse is right and natural and may not talk with my college-aged daughter about the risks it presents for transmitting HIV. Research has shown that education about sex and drugs does not increase sexual activity and drug use. The effect of educational efforts is to increase the level of safety precautions taken by those who are already sexually active or experimenting with drugs. Think about ways to share your values with your child at the same time as you tell them the facts about HIV transmission and risk reduction.

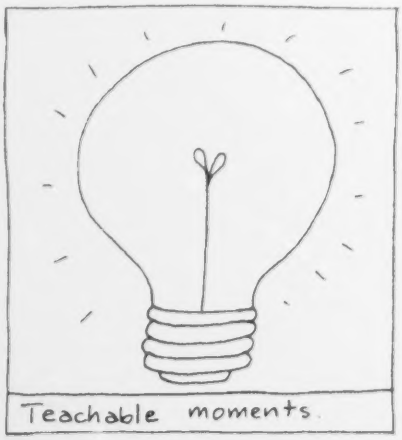
Conversation Building Block Number Four: Affirm your child

Think about several ways you can affirm your child during your conversation: by listening to them, by praising them, by telling them you care. The fact that you are talking with them about AIDS shows that you respect and care about them.

Conversation Building Block Number Five: Good times and places to talk

If you are planning a special conversation about AIDS and HIV, think about a good time and place to have it. Make sure that the groundwork has been laid and that a climate of open communication about issues of sexuality has already been established. AIDS should *not* be the topic of a first talk with your child about sexuality. Think about how much time the conversation will require and plan for enough time. Plan something fun and relaxing to do before, after, or during the talk.

Teachable moments



This kind of thinking will also help you take advantage of teachable moments—opportunities for talking with your child about AIDS and HIV that arise naturally. All of us are most interested in learning when we have an immediate need for information or when something happens that makes us seek answers to specific questions. Gifted teachers sometimes have a special ability to recognize teachable moments and to respond to them. You can take advantage of a variety of teachable moments in relation to AIDS. Your child may come home from school with questions about AIDS or see a show about AIDS on television. Your teenager may ask to go to a party and imply that some of the kids planning to be there are sexually active. You may learn that someone in your family or neighborhood has HIV or AIDS. Your child may simply ask you a question about AIDS out of the blue.

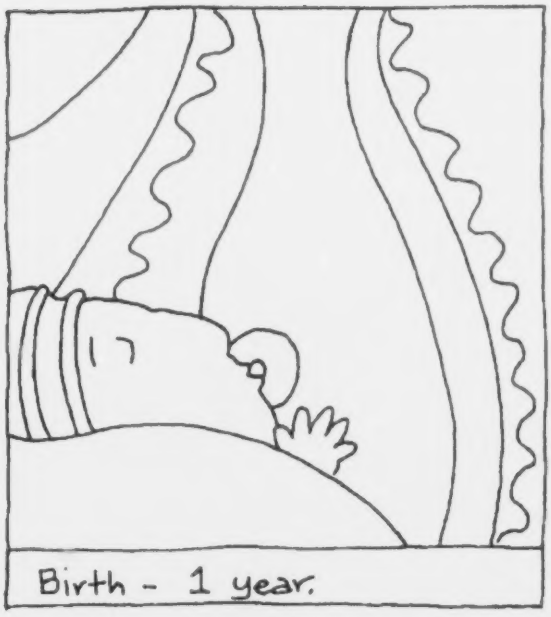
How you teach your child about HIV/AIDS depends on the child's questions and concerns, level of understanding, age, prior knowledge, learning style, and your communication style.

Age Group Charts

While each child is unique, children in a particular age group share many growth and development characteristics. Children face different potential risks for HIV infection at different ages. The following charts outline some ways adults can help children of various ages to keep healthy and prevent HIV transmission.

Infants

(Birth to one year)



Growth and development of infants

A baby's first year is a time of rapid growth and change. A baby discovers and explores its own body and its immediate world. Newborn babies can move their arms and legs around in the air, but they can't hold up their heads or sit up or stand up—gravity is too much for them. Babies develop their sense of balance and become stronger as the months go by. They become able to hold up their heads, sit up, creep, crawl, and stand. During the first year, the baby develops a sense of trust that its mother, father, or primary caregiver will meet its needs for food, comfort, dryness, cuddling. Infants experiment with conversational sounds and may even say a few words by the end of the first year. They delight in simple play.

How infants may be at risk for HIV infection

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Most babies with HIV became infected this way.

A baby may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

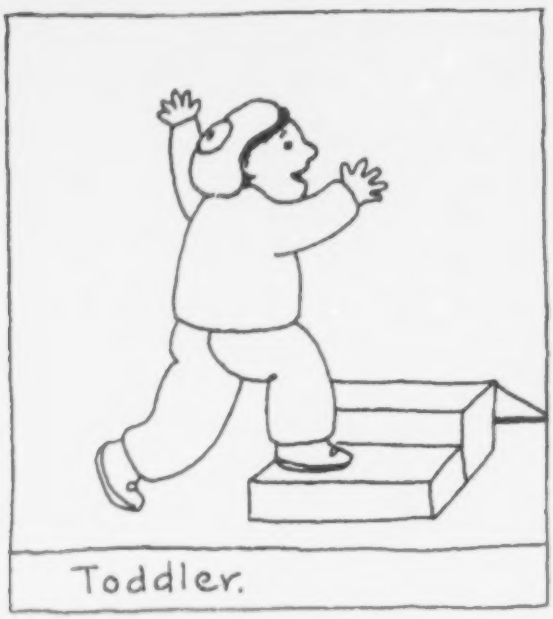
A few babies worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

Simple things adults can do to promote infants' health

Infants are dependent upon adults. Adults anticipate and respond to a baby's basic needs for food, comfort, dry diapers, cuddling. This helps the baby to grow and to stay healthy. It also helps the baby to develop a sense of trust. Adults are responsible for keeping the environment safe for babies. Falls, drowning, and suffocation are big risks for babies and can usually be prevented by simple "childproofing" measures. Adults can encourage a baby's discovery of its immediate world. Mobiles, bright forms, faces of loved ones, peek-a-boo games are full of visual discoveries for a baby. Babies discover their own bodies while bathing, waving their arms and legs in the air and tasting their fingers and toes. Normal babies experience different growth patterns and behaviors—each baby is a unique individual. Even with babies, adults can use the correct terms and talk about all body parts. This will help to build a foundation for teaching about sexuality and health later. Adults need to understand that erections are normal for baby boys and that discovery of the genitals is a natural part of learning about and exploring the body.

Toddlers

(one to three years)



Growth and development of toddlers

Toddlers are always in motion. They learn by taste, touch and sight. Toddlers may have wide and sudden mood swings. They develop increasing mobility first standing and walking, then running, jumping, climbing stairs. They move quickly and do things on impulse.

Toddlers use one word, then multiword statements. They build a sense of grammar and a big 900-word vocabulary by the age of three (including "me," "mine," and "no"). Desire for exploration and independence appears. Toddlers show interest in using things such as plates, spoons, toilets.

They play beside, not with, peers. Toddlers like rituals, such as the same food in the same spot on the same dish.

Toddlers show interest in the differences between male and female bodies and express the interest by doing things such as following men to the bathroom and touching women's breasts.

How toddlers may be at risk for HIV

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Most toddlers with HIV became infected this way.

A toddler may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

A few toddlers worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

Toddlers are often victims of sexual abuse, which can result in HIV transmission.

Simple things adults can do to promote toddlers' health

Toddlers are dependent on adults. Adults need to provide toddlers with a safe, supportive environment for growth. If you have a toddler in your life, here are some ways you can promote their health and safety now and build a foundation for their future health.

Recognize the toddler's process of learning by imitation, play, taste, touch, exploration.

Teach toddlers simple self-care, health and safety skills (dressing, brushing own teeth, resting if tired).

Teach toddlers that pills are not candy. Always keep medicines in childproof bottles.

Teach toddlers correct names for all body parts.

Answer the toddler's questions about sex or AIDS simply and concretely. The toddler won't understand abstract details about AIDS or adult sexual behaviors.

Support the toddler's sense of competence in exploring the immediate world, and provide a safe, reliable point of return.

Use "do's" instead of "don'ts" when you want to change a toddler's behavior (for example, try saying "Keep your applesauce in your bowl, Tommy" rather than "Stop putting that applesauce on the cat right this minute, Tommy!").

Begin to teach toddlers about privacy—that some activities such as bathing, using the toilet, or touching own genitals are private, and that adults sometimes need private time.

Toddlers are especially vulnerable to ear and respiratory infections and to accidents.

Preschoolers

(Four to five years)

Growth and development of preschoolers

The preschooler's increasing competence means expanding horizons to explore. Preschoolers spend hours in imitative play (such as playing house). Lack of full coordination may lead four-year-olds to talk too loud or squeeze the cat too hard. Five-year-olds probably can "fine tune" their behavior to adult tastes, accept simple responsibilities, take care of many of their daily needs such as dressing (but wait a while before expecting the child to tie shoelaces). Preschoolers are active learners and gain knowledge by doing, not by verbal explanations. They start to identify with adults rather than simply relying on adults.

How preschoolers may be at risk for HIV

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Because of improved care, these babies are living longer, healthier lives.

A preschooler may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

A few children worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

Preschoolers are often victims of sexual abuse, which can result in HIV transmission.

Simple things adults can do to promote preschoolers' health

Support the preschooler's basic self-care skills.

Teach preschoolers basic "street safety"—how to cross the street, never to talk to or go with strangers, own name and address and phone number.

Teach preschoolers never to take drugs or or medicines without your approval (and don't give children alcohol or any other "recreational" drug).

Keep the home environment childproof by keeping objects such as knives and household chemicals out of reach.

Help preschoolers to continue learning social limits (for example, being touched by adults in sexual or painful ways is something to refuse and report to another, trusted adult).

Answer questions about AIDS and sex directly, simply, and concretely.

Coloring books or drawing pictures may be useful in helping preschoolers to understand basic information about AIDS and other topics.

Use concrete situations such as a cold or a cut finger to explain how germs cause sickness.

Support the child's vocabulary-building—a five-year-old probably knows about 2000 words!

Recognize that "playing doctor" is normal as preschoolers explore their own bodies and become curious about friends' bodies.

Keep offering comfort, love, and a safe, accepting place to be.

Young school-aged children

(Six to eight years)

Growth and development of young school-aged children

Children of this age experience slower growth and change than younger and older children. They begin to think about issues such as life, death, sickness, religion, and sexual relationships. They probably have heard about AIDS. The early-school-aged child may have projects or near-obsessive hobbies. They may see things as absolutely right or absolutely wrong. The child may become a commuter between home and school daily. At this age, the child becomes very interested in taking part in "adult" projects (cooking, building, sports). The school-aged child develops a sense of mastery over more and more components of culture and society.

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How six-to-eight-year-olds may be at risk for HIV

A woman with HIV infection may transmit the virus to her baby during pregnancy or childbirth. Because of improved care, these babies are living longer, healthier lives.

A young child may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

A few children worldwide became infected with HIV after drinking breast milk from a woman with HIV infection. Women with HIV need to have this information if they are considering breast-feeding.

Young children are often victims of sexual abuse, which can result in HIV transmission.

School-aged children could risk HIV infection during play that involves sharing needles or other implements (such as becoming blood brothers).

School-aged children sometimes use injectable drugs and could risk HIV infection by sharing needles and syringes. Diabetic kids need to learn never to share needles and syringes and always to dispose of used injection equipment properly.

Simple thing adults can do to promote kids' health

Answer the child's questions about AIDS and emphasize that people don't get AIDS as a punishment for being bad. The child may express fears about AIDS and need reassurance.

Support the child's sense of productivity by encouraging and praising activities, projects, school work, sharing in adult tasks.

Support the child's positive sense of sexuality, privacy needs, physical competence.

Encourage the child to refuse and report abuse or sexual abuse

Encourage the child to refuse alcohol and non-medicinal drugs, whether offered at school, at home, or on the streets.

Build the foundation of knowledge the child needs for puberty. Teach the child basic facts about human reproduction and sexuality. The child's curiosity about intimate objects such as condoms and sanitary napkins may be a good starting point for talks.

Encourage the child's school to provide accurate AIDS awareness education.

Preteens

(Nine to twelve years)

Growth and development of preteens

This age brings another period of rapid physical growth and change. This leads to strong concern with bodies, appearance, being "normal," as well as intense curiosity about sex. In some children of this age, hormones leading to puberty are already at work. The development of secondary sexual characteristics (such as swelling breasts, growth of pubic and underarm hair, broadening hips, deepening voice) begin as kids stand on the threshold of adolescence. Girls may grow and develop sexually faster than boys. Gay and lesbian people often recognize their sexual orientation at this age and may experience tremendous fear, confusion, and isolation in a heterosexual world. Peer groups become very important. Kids test out values learned at home in the context of their peer groups. Preteens experience powerful social pressures for conformity.

How preteens may be at risk for HIV

A child may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

Children are often victims of sexual abuse, which can result in HIV transmission.

Kids could risk HIV infection during play that involves sharing needles or other implements (such as becoming blood brothers).

Kids sometimes use injectable drugs and could risk HIV infection by sharing needles and syringes. Diabetic kids need to learn never to share needles and syringes and always to dispose of used injection equipment properly.

Sexual intercourse and sexual experimentation may place kids at risk of HIV transmission. Kids may trade sex for food, money, drugs, or shelter.

Simple things adults can do to promote kids' health

Recognize that preteens stand on a threshold—sometimes they are children, sometimes they are adolescents.

Preteens are curious about sex, need accurate information, and can understand that sexual intercourse has consequences including HIV infection and pregnancy.

Teach preteens about menstruation, condoms, reproductive health, HIV/STD prevention, sexual decision making.

Consider teaching your child specifics about condom use and needle safety—it won't push them to try sex or drugs and may help protect their life. Preteens can grasp a full explanation of HIV transmission and prevention.

Remember that our culture puts special pressures on preteens as their bodies, hormones, and emotions go through tremendous changes. Now is a time to share your values concerning sexual relationships, substance abuse, and other issues in two-way talks with your child. Listen to your child as well as telling them your thoughts.

Encourage your child to stay free of alcohol and drug use, and act as a positive role model.

Encourage your child's school to offer accurate AIDS-awareness and HIV-prevention information to each grade level.

Teens

(Thirteen to eighteen)

Growth and development of teenagers

"Adolescence" is derived from a Latin word for "coming to maturity." Puberty begins with a growth spurt and changes in hormonal activity. It ends in sexual and reproductive maturity. Where adolescence ends and adulthood begins depends on social and legal norms as well as individual physical and emotional factors. Adolescents in American society struggle to lay down the foundation for their adult identities. Because our society supports the isolation of teens from adults and the separation of teen culture from adult culture, this struggle for identity is often stormy. It may involve a variety of risk-taking behaviors. Teens may take chances with sex, drugs, high-speed driving, robbery. Sometimes, teens separate themselves from home and family by running away. They may run away to escape physically abusive situations. Adolescence also involves a search for intimacy. Some teens even try to become pregnant so their intimacy needs will be met: "The baby will be one person who really loves me." Teens may experience their first successes with adult roles and tasks (e.g., having a job).

How teens may be at risk for HIV

A teenager may have become infected after receiving transfusions or blood products containing HIV. This is rare in the United States since blood donations began to be screened for HIV antibody in 1985.

Teenagers are often victims of sexual abuse, which can result in HIV transmission.

Kids could risk HIV infection during play that involves sharing needles or other implements (such as becoming blood brothers).

Kids sometimes use injectable drugs and could risk HIV infection by sharing needles and syringes. Diabetic kids need to learn never to share needles and syringes and always to dispose of used injection equipment properly.

Sexual intercourse and sexual experimentation may place kids at risk of HIV transmission. Kids may trade sex for food, money, drugs, or shelter.

Simple things adults can do to promote teens' health

Contrary to the popular fear, teens do not stop talking or listening to adults. Giving lectures, however, rarely works with teens.

Remember to really listen to your teenager; often adults do only one fifth of the talking in an effective conversation with a teenager.

Try to break down the isolation of teens from adults by "mentoring" teens—teaching them skills, sharing your values and thoughts, asking about their own values and thoughts.

Teach teens complete and accurate information about sexuality, HIV transmission and prevention, HIV-safe sexual behaviors. Teens are able to learn and understand the wide range of HIV/AIDS information available to adults.

Encourage schools to provide complete and accurate HIV/AIDS education programs.

Accompany teens to panel discussions that include young people with HIV/AIDS.

Recognize the turmoil teens in our society confront as they build their identities. Remind them frequently of their strengths and abilities. Catch teens doing things right more often than you criticize them for doing something wrong.

Support teens in recognizing and confronting sexual abuse or exploitation.

Encourage teens to stay free of substance abuse.

And remember to tell teens as well as young children that you love them.

Values and HIV prevention

It is often hard for people to talk frankly about their values because values reveal so much of who we are, what we think, and how we live our lives. AIDS is a sensitive topic to discuss because so many of our values relating to life, death, sexuality, responsibility, drug use, and many other areas may be revealed in the process of the conversation. Your talks about AIDS with young people will probably involve discussion of your values and their values.

Values play a very large role in choices people make about what they do. Values grow out of life experiences, moral and religious teaching, family and community expectations, and peer expectations. Values vary from person to person and from society to society. The United States is a pluralistic society in which many strong value systems coexist. Sometimes the values expressed by different systems confirm one another. Sometimes they stand in contradiction to one another. Some value systems possess internal contradictions.

Young people in this society are presented with a variety of often conflicting values. For example, the media contain sexually explicit and provocative ads targeted at young people at the same time as national campaigns encourage young people to say no to sexual activity. Young people have probably experienced values conflict in areas directly related to HIV prevention, such as drug use and sexuality. A young person may feel at a loss to make positive, consistent risk-reduction choices in a situation that presents so many conflicts and contradictions. Adults don't always offer good role models, and often there is not a clear "right" way of doing things.

One task in teaching young people about AIDS is to assist them to be clear about their values and to make choices consistent with these values that reduce their risk of HIV infection. Their value-informed choices will be more durable than choices made in contradiction to their value system. Sometimes you may want to bring young people's values and actions in line with your own values. While young people may not automatically accept your values, they often care about what you think and want to understand what you believe. Discussions about values and how choices are made on the basis of values are an important part of talking with your children about AIDS.

The authors of the "Talking with Kids about AIDS" program hold these values:

- People's lives are precious. HIV infection is a threat to people's lives and health. Therefore, we value working to reduce the spread of HIV.
- The lives of people with HIV are as precious as the lives of people who do not have the virus. Work to stop the spread of HIV must also support the well-being of people living with the virus.
- Parents and other adults who care have special skills and insights in relation to teaching the young people they love about HIV and other topics.
- People can learn and act effectively to stop the spread of HIV regardless of their educational backgrounds, sexual orientation, socioeconomic background, race, gender, drug use history, or other cultural variables.
- Diversity makes us strong. We will not promote or prescribe any one set of values or any one method of reducing the spread of HIV.

Assessing your child's concerns and risks

How we assess and learn to reduce the risk of HIV transmission are very closely linked to our values. For example, I may be reluctant to view activities that I or my peers value as potentially risky. Because this blind spot could increase my risk of HIV infection, it is very important for me to learn how to assess risk objectively to determine what kind of changes I need to make. This skill is important in relation to the young people you care about. You can teach them how to assess activities for their risk of HIV transmission. Risk assessment is a useful skill to develop and apply to other areas of life as well. As a parent or guardian, you will probably sometimes do that assessment yourself and then discuss it with the young person you care for.

Sometimes children face risk of HIV infection from situations they do not have the power to change. They may be born infected or become infected after receiving a blood transfusion or a dose of clotting factor.

A small number of children have become infected with HIV after being sexually abused or raped. Whether or not you are concerned about HIV transmission, if you feel that a child has been or is being sexually abused, it is very important for you to report it. The child's life and

health are being jeopardized by the abuse. If the child also becomes infected with HIV, it compounds an already serious tragedy.

If you are a foster or adoptive parent, you may learn that your child has a past risk of HIV infection or has special fears about AIDS and HIV.

Children and young people also may be at risk for HIV infection from drug use or sexual activity they have chosen to become involved in. Children in the later years of elementary school may already experiment with drugs or be involved in early sexual experiences. As young people enter their teens, they are increasingly likely to experiment with sex. Two-thirds of U.S. teenagers have experienced sexual intercourse by the time they are 18. Each year, one out of seven teenagers gets a sexually transmitted disease. Teens may experience increasing social pressures to use drugs, which may involve sharing needles for either subcutaneous or intravenous injections. Teens and pre-teens may share needles for tattooing or ear-piercing.

Before you talk with your child, think about what their risk may be. Think about whether or not taking this risk is consistent with your value system. What will you feel if you learn that your child is at risk because of a certain activity? What will you think? What will you say or do? Do you have a plan to help them reduce their risk? Is there an action you feel you should take, such as reporting sexual abuse or buying condoms and spermicide to give to them?

Over the years, you will probably need to have many different conversations with your child about AIDS. Young people need different information at different ages, and you will have new facts and insights to share with them. In the same way, their lives will change and the risks they may face will change especially as they mature sexually. It is important to start to build the foundation for learning to reduce your child's risk of HIV infection now, even if they are now very young and you know that they are currently not at risk at all. Get into the habit of talking to your child about sex and AIDS before the emotionally tumultuous and sensitive period of puberty and adolescence begins. But remember, even if your child already is an adult, it is never to late to learn to talk with them about HIV/AIDS.

CHAPTER 3

Risk and Change

Reducing your own risk for HIV infection, or helping someone else to stay safe or reduce their risk, can be hard. Although it is very important to understand the facts about HIV transmission, actually keeping safe takes more than knowing these facts. Putting this potentially lifesaving knowledge to work often means taking new kinds of risks, such as talking about sex or drug use or changing the sexual patterns of a relationship.

In this society, people rarely talk about things that we view as private, such as sex or drug use or religion or paychecks. We may not even talk frankly with our best friends, spouses, or partners about such intimate things! This chapter will address some of the complex issues involved in putting your

knowledge of HIV risk reduction to work and increasing your comfort level when talking about difficult life issues.

Change almost always involves a sense of loss. Multiple changes threaten individuals with increasing feelings of loss. Too many changes at once may threaten a person with more than they can bear, making it impossible for them to change at all.

HIV risk reduction involves very intimate aspects of people's lives. Even small changes in sexual expression have far-reaching consequences in people's relationships, sense of self, sense of belonging. This is one of the reasons why HIV risk-reduction education needs to be very specifically focused and sensitive to the "intimate culture" of people involved. The goal of presenting information is not to change people's sense of self or their intimate culture. The goal is to give people the informational resources they need to reduce the spread of HIV. Adopting this information may mean they choose to change their sexual expression in specific, limited ways.

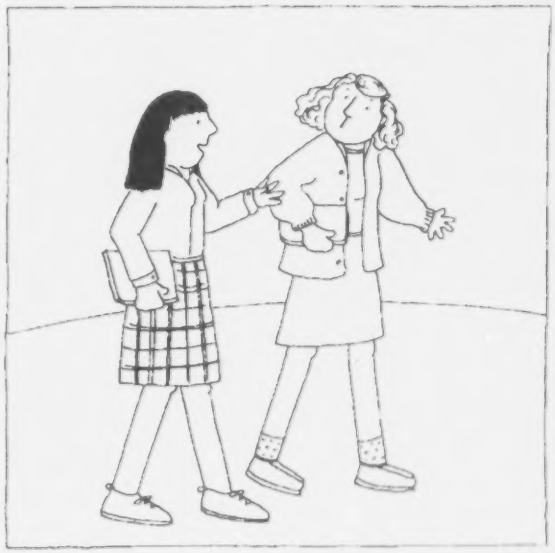
Considerable sexual communication occurs without words, through body language, and happens in contexts where partners assume (rightly or wrongly) shared norms and expectations. Expected sexual norms are powerful influences on people's behavior in many situations: in gay or heterosexual singles bars, during teen-aged dating, between established partners or spouses. Similarly, there are norms surrounding drug use and needle-sharing that are so strong that some researchers even refer to them as rituals. Reducing the spread of HIV depends on finding ways to change community norms so that people *expect* to act in ways that present little or no risk of transmitting HIV.

Many studies on the practice of safer sex in gay men's communities have looked at the relationship between learning the facts about HIV transmission and practicing safer sex. These studies have shown that peer pressure begins to support safer sex and other HIV risk-reduction efforts when the community's norms for sexual expression change. Then, as more men practice safer sex, the community's new norm is strengthened.

Educational efforts by gay men have shown success in reducing the incidence of sexually transmitted diseases including HIV *while* affirming that sexual expression is a very positive, joyous aspect of their lives and identities. The sexual norms of a community can change without jeopardizing the community's sense of identity or validity. This kind of change is more acceptable and is more apt to be adopted than change that threatens to obliterate the community's sense of itself. The results of these educational efforts may offer hope that other communities and individuals will adopt safer sexual and drug use behaviors as they learn about HIV and safety skills.

There is no one process that individuals or communities go through as they replace high-risk activities with activities that have lower risk of transmitting HIV. There are some themes, however, that are often part of the process. This chapter illustrates these themes by telling the stories of several people as they learn about AIDS and HIV prevention.

Learning about HIV/AIDS



The starting point in the change process often is learning something about AIDS and HIV. This may happen during a conversation with a friend, an in-service day at work, a PTA meeting, or a special class. It may happen during a conversation with your thirteen year old child or when reading the newspaper.

Charlotte's Story

It's 1987. Charlotte is a young white woman, 15 years old, who lives in a small city in upstate New York. She's just learned from a girlfriend that there's a disease called AIDS. She's told that mostly gay men and IV drug abusers are at risk.

Eva's Story

Eva is a 34-year-old Latino woman, with three school-aged children. In 1988, her daughter comes home from a ninth-grade health class and tells her that you get AIDS from having sex.

Jack's Story

It's 1986. Jack is a 25-year-old African-American man who's just moved to New York City. He decided he was gay while he was in college, but he's never had a sexual relationship with a man. He is handed a pamphlet about AIDS as he walks down the street near his home.

Steve's Story

Steve is a man of Native American descent who works as a nurse in the medical ward of a large hospital. Most of his patients are elderly people waiting for rooms in nursing homes. He is heterosexual, 34 years old, and has been a nurse for the past fifteen years. In 1987, the hospital starts a series of in-services on "universal precautions" that contain a lot of information about AIDS. He wonders why he has to attend these in-services, because most of his patients are so old they certainly wouldn't be at risk!

Meili's Story

Meili is a Chinese-American woman. She's 40 years old and came out as a lesbian when she was in college. She began using recreational drugs during the early 1970s and has been shooting heroin more and more frequently in recent years. It is 1984 and Meili is becoming frightened that what once was casual drug use has become an addiction. She feels even more frightened because rumors are spreading about a new disease affecting IV drug users called AIDS.

Mary and Jamal's Story

It's 1990. Mary and Jamal have been together for three years. They live in a solvent working-class African-American neighborhood in a large city. Jamal, who is thirty-one years old, works as a bus driver with the city transit authority. Mary is twenty-eight and works in the admissions department of a general hospital. More and more of the patients coming into the hospital have AIDS-related illnesses.

Think about the first time you learned enough about AIDS and HIV to feel curious and to want to learn more. What did you learn and where did you learn it? How did you react?

Taking the information in

People often say that they learned about something years ago, but it didn't really hit them until recently. People sometimes feel that information hits home when they realize that it has direct bearing on their own life or on the life of someone they care about.

Charlotte's Story

It's 1988 and Charlotte is 16. She skipped a period and is afraid she's pregnant, so she goes to a family planning clinic for a pregnancy test. The nurse who talks to her there says they also do HIV antibody testing and gives her a pamphlet on AIDS. The pamphlet says that girls can get the virus from sex, the same way they can get pregnant.

Eva's Story

Eva attends a PTA meeting about AIDS at her children's school in late 1988. The reason for the meeting, the principal says, is that he wants to make sure that parents and students understand that it is safe for a student with HIV to be enrolled in the school.

Jack's Story

It's 1987 and Jack has fallen in love. Chris is a 37-year-old white man who lives downstairs from Jack. They met several weeks ago and are very attracted to each other. Though they have not made love, they both are thinking about it. Chris tells Jack that the man he had lived with for a long time died of AIDS last year.

Steve's Story

Steve applies for a new job in his hospital as head nurse of a drug detoxification unit. He is excited when he gets it. The first day on the job, he learns that several of the patients on the unit also have symptoms of AIDS.

Meili's Story

It's 1987 and Meili is trying to quit her heroin habit. She has just gotten into a methadone maintenance program and happens to meet a long-time friend there. They go out for a cup of coffee to catch up on each other's news. Meili is shocked when he tells her he has AIDS. He tells her she'd better go get tested and that it's a lie that Asians are immune to the virus that causes AIDS. He says he knows several lesbians with AIDS, too. Meili is shocked and frightened. She thinks about how she often shared works with this friend years back. She feels so much stress that she quits the program and starts shooting heroin again. Her lover, Ruth, breaks off the relationship because Meili has gone back to using drugs.

Mary and Jamal's Story

One day Mary does the admission paperwork for a twenty-eight-year-old woman with AIDS. For some reason, it hits Mary hard that this woman has AIDS. Sheila, the woman with AIDS, is very thin and coughs a lot and has to ask Mary to repeat the questions before she can answer them. Mary feels this will be Sheila's last trip to the hospital and then tries to get herself to think more objectively and feel less. As she sees Sheila wheeled away down the hall, Mary thinks, "That could be me," then stops herself and gets on with a new admission. At dinner that night, Jamal asks Mary why she is so quiet. She says that a patient at work left her feeling upset. He asks what happened. Mary says that nothing really happened, but she had to admit a woman with AIDS who was just her age, who seemed like someone she could have grown up with. "It left me wondering what I'd do if I had AIDS." Jamal says, "There's no way you could have AIDS—you're not that kind of a person."

Have you experienced a situation when you began to view AIDS differently, as something that could have a direct impact on you? If you have, think about that situation and how you reacted to it.

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Gathering more knowledge

Sometimes, when information about AIDS begins to hit home, people feel that they don't know enough or that what they know isn't exactly the information they need. They work to gather more information that addresses the specific questions they need answered.

Charlotte's Story

Charlotte calls her boyfriend and asks him what he knows about AIDS. He yells at her that he's "not queer," then hangs up on her when she tells him that she's had a pregnancy test. She calls up her girlfriend, who doesn't know much about AIDS either but says she'll go back to the clinic with Charlotte. They go back and find out that they can meet with a counselor and learn more about AIDS and the virus that causes it. The counselor also says the clinic could offer them HIV antibody tests. Charlotte meets with the counselor who asks her lots of questions about what she and her boyfriend do and whether either of them does drugs and whether or not either of them sleep with anybody else. The counselor also talks about safer sex and shows Charlotte a condom. She asks Charlotte whether she feels okay about getting her boyfriend to use a condom and if she understands why it's important. Charlotte says she isn't sure, about either thing. They talk some more, then the counselor gives Charlotte a list of phone numbers, a pamphlet on safer sex and cleaning needles, and a half-dozen condoms. She says Charlotte can come back and talk again if she wants to.

Eva's Story

Eva is worried after the PTA meeting. She suspects that there is a child with HIV in her children's school, and she's just not sure that there really aren't any risks—that section of the meeting was very short because they spent a lot of time discussing policies. During the weekend, she asks her children what they think about going to school with a child who might have the virus. They all say they would feel fine and call her old fashioned when she says she's worried. Her ninth grader gives her a bunch of pamphlets, which she reads. One of them has a local hotline number on it. Eva calls and talks to the volunteer on the line for about twenty minutes. The volunteer mails her more information, including a pamphlet in Spanish that explains more about AIDS.

Jack's Story

Jack joins a group of gay men that is supposed to discuss safer sex. He is nervous, but he wants to learn more about AIDS and about prevention. He reads the pamphlet they give him on safer sex, feeling a little bit embarrassed. He also feels embarrassed in the group to admit that he's never had sex with anyone, but finds that no one makes fun of him. They do role-plays about "negotiating" safer sex and talk about the impact AIDS has had on their lives. Jack tells Chris he's joined the group and asks Chris about how it felt to have a lover die of AIDS.

Steve's Story

Steve telephones the infection control officer of the hospital and asks why there aren't blood and body fluid precaution signs on the rooms of patients with AIDS. She explains that universal precautions should be practiced with all patients and will keep health-care workers from becoming infected by a variety of disease-causing organisms, including HIV. She explains that, although HIV is only found in blood, body cavity fluids derived from blood, semen, and vaginal secretions, their hospital's policy is that workers should put gloves on to touch any body fluids, including urine and saliva. This, she says, protects workers from becoming infected with other organisms such as Cytomegalovirus that could be transmitted by these body fluids. She reminds him that there are containers for used needles and syringes in every room, as well as a box of gloves. As head nurse, he should be sure that he uses these consistently and properly and make sure that other staff on the unit do as well. She says she'll do extra in-services for the detox staff anytime they wish.

Meili's Story

It's 1988 and Meili feels desperate. She gets very sick each time she tries to go without heroin and realizes she can't quit alone. She's been on the waiting list for a drug treatment program for six months. Meili went for an HIV antibody test three months ago but feels too scared to return for the results. She can't think of anywhere to turn if the test shows she is infected. Meili avoids the street outreach workers from the AIDS program until one day she bottoms out and shoots up with a dirty needle. Then she suddenly feels like she has to make some changes. She keeps hearing "die of drugs or die of AIDS" in her mind. Meili hurts so bad sometimes—that's why she started shooting—but she doesn't want to die yet. So she lets a street outreach worker walk up to her today. He says he used to shoot and share needles and then learned he was HIV-positive. Now he wants to help other people keep safe. He gives Meili a kit with a little bottle of bleach, some condoms, some clean cotton, and a bunch of cards with phone numbers on them. He asks Meili if she knows how to clean her works.

Mary and Jamal's Story

Mary still feels sad when she thinks about Sheila, who died a few days after entering the hospital. Mary decides she's thinking about AIDS so much that she should get some more information on it. She calls the AIDS hotline and they tell her the name of an organization in her community that does AIDS education. Mary stops by on the way home and talks to the volunteer staffing the office—a woman about her age. After a while, Mary asks the volunteer how she can figure out if she could be at risk for AIDS. The volunteer explains that there is a free and anonymous HIV-antibody testing program in the neighborhood and tells her how to make an appointment with a counselor there. Mary makes the appointment and then is confused about whether she should tell Jamal. She knows he doesn't like to admit that she had a boyfriend before him or that he lived with another woman before they met. She decides, for now, not to talk to him about the test.

When Mary goes for her appointment, the counselor explains to her that HIV is the virus associated with AIDS, that it takes a long time to go from just being infected to actually being sick, and that HIV is like other sexually transmitted diseases—it can be transmitted through intercourse, and prevented by using a latex condom during intercourse. Mary has never used a condom, so the counselor teaches her how and even has her demonstrate putting one on her fingers. The counselor tells Mary that she thinks it's really important to use condoms if she has intercourse until she knows that neither she nor Jamal have the virus. The counselor gives Mary a handful of different condoms, tells her to get Jamal to come in for a test, draws the blood sample, and sets an appointment in four weeks for Mary to come get her test results.

How would you get answers for informational or personal questions about AIDS? How do you respond when the first information you get doesn't answer all your questions? What do you do if you feel overwhelmed by new information?

Assessing risk

Looking at your own, your partner's, or your child's potential risk for HIV infection is hard to do. On the one hand, acknowledging real risk is difficult, because it is frightening. On the other hand, AIDS plays a big role in our society today, and sometimes it is possible to feel doomed even when the risk of infection is quite small. Learning to assess risk realistically is an important part of the risk-reduction process.

Charlotte's Story

Charlotte calls her boyfriend. He's out, so she goes and finds him at the arcade. They go for a drive and she tells him all the stuff that the counselor told her. They park for a while and he asks her if she's pregnant. She says she doesn't know yet, but that the counselor told her that if she could be pregnant, she could have gotten the AIDS virus if he had it. He says she really should go on the pill. She says that the pill wouldn't make any difference about AIDS. She asks if he's ever slept with anybody else. He says he hasn't slept with any guys. She says what about girls. He says he's slept with some girls, but that guys can't get AIDS from girls. She says the counselor said they could. She asks if he's ever had VD. He says it's none of her business. She asks if he's ever shot drugs. He says he didn't come out with her to get the third-degree.

Eva's Story

Eva reads the pamphlets, and thinks about the phrase "casual contact." She's pretty well convinced that HIV can't be spread by shaking hands or sneezing. But what if her kids were in gym with a child who had the virus? What if the child got a nose bleed? She calls the school nurse, who explains the school policy of always using gloves to clean up blood and making sure that students learn basic facts about germs carried by blood and about first aid. She asks her kids about what they *really* do in school, and do they really think it would be okay to have a child with AIDS sitting next to them in class. Her oldest daughter looks like a know-it-all when she says, "As long as we don't have sex or shoot drugs in class, I'm sure it will be fine." Eva laughs at the know-it-all tone, even though she's a little shocked her daughter would talk about such things.

Jack's Story

Jack feels sort of surprised that he is still in love with Chris after learning so much about AIDS. He asks Chris whether or not he has HIV, and Chris responds that he feels healthy, that he has chosen

not to go for an antibody test because he'd rather not know for sure, and that he'd rather assume the worst (that he's infected) and hope for the best (that he's not). Chris says that if they become lovers they'd just have to always practice safer sex.

Steve's Story

Steve's wife is very concerned when she learns that he has patients with AIDS. She is worried that their children will be exposed to the virus. He thinks about the hands-on care he gives to his patients and decides that the only real risk he faces would be from an accidental needle-stick.

Meili's Story

Meili says she has only shared with friends—is that really risky? The outreach worker says that half of the drug users in the city are already infected. Does she know for sure that all her friends are healthy? Friends can spread the virus to friends just as easily as strangers spread it to strangers. It shows no respect for friendship! Meili thinks about her old friend. She hasn't seen him once since that time at the program when he told her he had AIDS. She wonders if he's dead, then stops herself. She asks the outreach worker how to clean works. He shows her the 2+2 method and tells her where to get more bleach for free.

Mary and Jamal's Story

Mary is so nervous she feels dizzy the night after she talked to the HIV counselor. When Jamal comes to bed, she turns to him and says, "We have to talk." He doesn't say anything, so she turns on the light and sits on the bed hugging her knees. She says, "I know you may feel mad, but I went for an AIDS test today." He looks relieved for an instant, then confused. "You've been so quiet lately, I've been afraid you were thinking about leaving me. I'm glad that's not what's going on." "Leaving you! All I want is to stay with you." They hold each other for a while. Jamal says, "I'm glad you went for the test—I'll be glad when you get this AIDS idea out of your system. Those folks told you not to worry. People like us don't get AIDS." Mary says that the counselor told her HIV was a sexually transmitted disease and that the virus doesn't care if you're gay or straight. Jamal says, "I thought only addicts got it, or gay men." Mary says, "Sheila never shot drugs. She only had two boyfriends." Jamal says, "You don't have to worry about me." "But I don't know about Royal." "Let's not talk about that." "Okay. But we need to talk about some stuff sometime." Jamal kisses Mary and says, "You know how much I love you, but it's an early shift tomorrow. Let's just *be* together now, and talk more tomorrow." Mary says, "I love you too, but I think we need to talk about some of this now."

When you think about yourself, or someone you love, how do you judge any potential risks of HIV infection? What kind of support and resources do you need to make a risk assessment? What feelings does it bring up for you?

Risking change

Once people have taken in information about AIDS and worked out in their own minds what ways they might be risking HIV infection, they may be ready to try to make changes. This is where risk-reduction information is put to use.

Charlotte's Story

Charlotte's boyfriend puts his arms around her in the parked car. He says that if she's pregnant already they can do whatever they want tonight and it won't do any harm. She hands him the condoms. He says he wouldn't be caught dead wearing things like that and gives them back to her. She gives them back to him and says that if he doesn't wear them, she won't have sex with him. He says they can talk about it later, now is now. She says later could be too late. He says he knows lots of girls who would put out for him without a condom. She says that's half the problem. He says skip it. She says yeah. He drives back to the arcade without saying anything. She says goodbye and leaves.

Eva's Story

One morning, Eva tells her kids that she thinks it's fine if they go to a school that would let in kids with AIDS. They grab their breakfast and go to school.

Jack's Story

Jack spends a lot of time thinking about Chris. He tries to think about what he might feel if they were lovers and then Chris got sick. He tries to think about how he'd feel if they never became lovers, or if he went away and never saw Chris again. He decides that he wants them to become lovers, and he tells Chris so. They don't talk about safer sex but they spend the whole night making love without going (or coming) inside each other. They talk about this in the morning, while drinking coffee in Jack's bed. They decide that they'll keep making love this way.

Steve's Story

Steve decides he will be especially careful with needles and that he'll stop putting the caps back on them even though that has been a habit of his for the past fifteen years. He's heard that recapping is when most needle-stick accidents happen. He explains to his wife how HIV is transmitted and reassures her that she and the children are not at risk. In private, he gives his wife

a pamphlet about safer sex. They discuss a worst case scenario and agree that they would practice safer sex if he ever stuck himself with a dirty needle. He thinks that this is unlikely—he's only stuck himself twice in fifteen years, and both those needles were sterile! As they go to bed, she smiles and says that some of that safer sex stuff sounded like fun.

Meili's Story

Meili decides that she'll use clean needles when she shoots. She figures she can clean her own works after she shoots up, or hold out just a few more moments to clean works she borrows before she shoots. She feels so afraid of dying. The thought of going for her HIV test results crosses her mind, but she pushes it away. She's scared to even hope she's negative. The outreach worker is still talking. He asks Meili to teach two friends about clean needles and gives her two extra kits. She asks if he knows about the AIDS test—can people take friends along? Does he know anyone who would go with her? He shows her one of the telephone numbers on the cards and says she should call. Maybe they have volunteers to help people with things like that. She asks him if AIDS outreach people know any treatment programs she can get into right away—she wants to quit and get clean for good. He looks sad and says he wishes he did. He knows how hard the waiting time can be. He asks Meili if she'll promise to use only clean needles while she waits.

Mary and Jamal's Story

Mary takes out the handful of condoms from underneath her pillow, and scatters them on the bed. Jamal says, "So what's all this now? You're already on the pill." Mary says, "The counselor said it would be best if we used these until my test comes back and until you get tested." "Are you kidding? They didn't think you were at risk, did they?" "They didn't think I was at bad risk, but AIDS is just a regular sexually transmitted disease, and you remember I told you Royal gave me the clap right before I left him." "I had the clap once too, but I was just a kid." "See? If we're lucky, neither one of us has the virus. But I'd like to know for sure. If I've got it, there are some things I want to do. And if you've got it, I want to take special care of you." "Stop talking as if we were sick. I'll go for the test. I know it would make you happy, and maybe it makes sense. But I wish you'd get a different job. That hospital makes you see things funny." "Okay. But we don't have to talk about jobs now. Let's talk about us." They kiss and hold each other. Using the condoms feels a little like an interruption at first, but Jamal likes it when Mary puts them on, and Mary likes them because they make his erection last a little bit longer.

Sometimes making changes feels risky, even when the change is positive. Have you ever made a change in what you did or thought that felt risky to you? What motivated you to make the change? Why did you feel that it was the right thing to do? What did you lose because of it? What did you gain because of it?

Changing norms

As each member of a group or a community learns about AIDS and HIV and then makes individual choices to talk about the issues and to reduce the spread of HIV, the norms of the community change.

Charlotte's Story

Charlotte calls her girlfriend, who comes over to Charlotte's house and finds her in tears. Charlotte tells her about the fight she just had with her boyfriend and says maybe it wasn't worth it. Maybe she should have just had sex without a condom. Charlotte's girlfriend says no it was worth it. If he's worth it, he'll change his mind. Charlotte asks if she really thinks so.

Eva's Story

A group of parents from the local school come to Eva's house with a petition about the school's AIDS policy. They think that the school should bar children with HIV from classes and give them home tutoring. They also think that the school shouldn't teach students about AIDS because it's "adult" information. Eva explains to them how she felt after the meeting, and how she got more information about AIDS. She says that she now feels okay about students with AIDS being in the school, even though it makes her sad to think about any young child being sick. She also says that her children taught her a lot about AIDS, so she is glad that they learned about it in class. She doesn't sign the petition, and she gives the parents some of the pamphlets that she found useful.

Jack's Story

Bill is an old friend of Jack's. Bill is worried because Jack has become sexually involved with someone whose former lover died of AIDS. Jack tells him that they always practice safer sex, and that he's not worried about infection. Bill says that he doesn't practice safer sex, but that he only goes out once in a while these days because he's so nervous about AIDS. Jack says that Bill is the one whose taking chances and gives him the address of a place that offers support groups for men concerned about safer sex and AIDS. Bill says he'll think about it.

Steve's Story

Steve needs to hire several new staff nurses for the unit. He notices that a few nurses who had seemed interested in working there turn down the job. He thinks it may be because they have heard there are patients with AIDS being treated there. He decides to ask questions about working with AIDS patients when he interviews prospective nurses and to give them some specific information on universal precautions and caring for AIDS patients. At least one of the new staff people he hires is especially interested in learning about the care patients with AIDS need.

Meili's Story

Meili is feeling real drug sick. She needs a fix and most of her veins are blown, so she needs someone to shoot the drug into a vein she can't reach herself. She finds someone who will and almost forgets about the bleach. Then she remembers and asks him to clean the works first. He says he always cleans the works right after someone shoots, but sure he'll clean them for her. She gives him her bleach kit and watches him draw the bleach up twice, then draw up the water and squirt it out. Meili wonders what he would have done if she hadn't asked; was the syringe really clean? She promises herself she'll always check that the works she uses are clean, until she gets into treatment.

Mary and Jamal's Story

Jamal is relieved when Mary's HIV antibody test comes back negative. He makes an appointment for himself. While Mary and Jamal wait for the test results, they do a lot of talking, and they keep on using condoms. They decide that if they are both negative, they want to try having a baby. When Jamal's test comes back and is negative, Mary stops using the pill. They decide to keep using condoms until her fertility cycles are regular again—and because Mary heard at work that using condoms right up to the time that people want to conceive a baby sometimes helps. Jamal has gotten so comfortable with using condoms that he sometimes gives them to the young men at work, along with some advice on being careful because "AIDS is a sexually transmitted disease."

Have you ever felt that you've helped to change the norms of any group you've been a part of? How was that situation similar to or different from one involving AIDS and HIV? How did you feel before, during, and after your experience?

Choices and changes

The process of making changes so that the spread of HIV can be stopped involves many factors. Each person deals with information and with change differently. Some people discuss things more intensively than others. Some people get new information by reading, some through talking with friends or with experts. Sometimes the scary process of changing a relationship goes well and the relationship is deepened. Sometimes relationships may end more easily than they change. The important thing to remember about HIV is that people are usually able to make choices that reduce their risk. The communities in which people live can support their choices. You can probably read through these stories and identify some community supports and resources that were very important for the people trying to learn about AIDS and to make changes that could prevent the spread of HIV.

We all are faced with challenges in this area. It is important that we help one another to meet them.

Resources for further reading

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GLOSSARY

This glossary provides definitions for words that are commonly used when HIV and AIDS are discussed. Some terms that are rarely used anymore because they are potentially misleading, such as "high-risk group," are defined because they are found in earlier literature about AIDS.

AIDS (Acquired Immune Deficiency Syndrome)
A condition caused by infection with Human Immunodeficiency Virus (HIV). HIV injures cells in the immune system. This impairs the body's ability to fight disease. People with AIDS are susceptible to a wide range of unusual and potentially life-threatening diseases and infections. These diseases can often be treated, but there is not yet a successful treatment for the underlying immune deficiency caused by the virus.

Antibodies
These are proteins that the body makes to attack foreign organisms and toxins. Foreign organisms and toxins are called antigens. Antibodies circulate in the blood. They are usually effective in removing antigens from the body. In infection by some organisms such as HIV, however, the antibodies do not get rid of the antigen. They only mark its presence. When found in the blood, these "marker" antibodies indicate that infection by HIV has occurred.

Antigen
Any substance—such as bacteria, virus particles, or some toxins—that stimulates the body to produce antibodies. HIV is an antigen.

Antigen Screens
Blood tests that are designed to detect the antigen instead of antibodies produced in response to the antigen. There are several types of HIV antigen screens.

ARC (AIDS Related Complex)
This term refers to the condition of immunosuppression caused by HIV infection. General symptoms of HIV disease are present, but none of the formal indicators of AIDS (such as specific opportunistic infections) are present. This term has been replaced by PGL (Persistent Generalized Lymphadenopathy).

Asymptomatic
Having no signs and symptoms of illness. People can have HIV infection and be asymptomatic.

Body Fluids
Any fluids made by the body. The only body fluids that are able to carry HIV into another person's system and cause infection are blood, semen, vaginal secretions, menstrual blood, breast milk, and body cavity fluids derived from blood such as cerebrospinal fluid, peritoneal fluid, amniotic fluid, etc. In talking about HIV infection, it is more effective to say "blood," "semen," or "vaginal secretions" than to use the general term "body fluids."

Candida
A yeast organism that lives in people's intestines. It can begin to grow in other parts of the body if a person is immunosuppressed. When Candida infects the mouth or esophagus, it is sometimes called "thrush." When Candida infects a woman's vagina and vulva, it is often called a "yeast infection."

CDC (Centers for Disease Control)
A federal health agency that is a branch of the U.S. Department of Health and Human Services Public Health Service. The CDC provides national health and safety guidelines and statistical data on AIDS/HIV and other diseases and health conditions.

CNS (Central Nervous System)
The CNS is made up of the brain and spinal cord. HIV has been found in the fluid surrounding the CNS and is believed to cause symptoms such as loss of coordination and balance, headaches, dementia, loss of recent memory and problem-solving abilities, and loss of hearing, speech and visual abilities. HIV is able to directly infect nerves and apparently does so in the CNS. Not all viruses are able to enter or infect the CNS, but HIV can.

Co-factor
A situation or activity that may increase a person's risk for progressing from asymptomatic HIV infection to symptomatic disease and AIDS. Examples of possible co-factors are other infections, drug and alcohol use, homelessness, poor nutrition, genetic factors, other systemic diseases, stress, surgery, or trauma.

ELISA Test
A blood test that detects the presence of antibodies to a specific antigen. An ELISA test is used to screen blood samples for the presence of antibodies to HIV. The test discovers HIV infection, not the symptoms of AIDS. The test is used for screening blood supplies and for seroprevalence studies. Sometimes it is employed in specific health care and diagnostic situations. If the ELISA test for HIV antibody comes back positive (detects antibodies), a confirmatory test is then done on the blood sample (see "Western Blot").

Epidemiology
The study of how diseases are spread.

False Negative
An incorrect test result that indicates that no HIV antibodies are present when in fact infection has occurred.

False Positive
An incorrect test result that indicates that antibodies are present when in fact there are none.

Hemophilia
An inherited condition in which a person's blood fails to clot effectively. Hemophiliacs often receive treatments with a blood product called Factor VIII. This puts clotting factors from other people's blood into their blood so that their blood clots effectively. Factor VIII is made from the combined blood of many individuals. Many hemophiliacs became infected with HIV when they were treated with clotting factor containing the virus. All clotting factor made in the United States is now heat-treated to kill the virus.

High-Risk Behavior
A term used to describe activities that increase a person's risk of transmitting or becoming infected with HIV. Examples of high-risk behaviors include oral, vaginal or anal intercourse without a condom, sharing injection needles, and so on. These are also often referred to as "unsafe" activities.

High-Risk Groups
This is an old and potentially misleading term. It refers to groups in which epidemiological evidence indicates that more people have been infected with HIV. In prevention, it is important to stress high-risk behaviors rather than high-risk groups. It is not groups but behaviors that transmit HIV.

HIV (Human Immunodeficiency Virus)
Infection with HIV injures the immune system, causing AIDS. This standard name was officially chosen in August 1986 to avoid confusion after different researchers in different countries gave the virus different names. You may see the virus referred to as HTLV-III (Human T-Cell Lymphotropic Virus Type Three), LAV (Lymphadenopathy Associated Virus), or ARV (AIDS-Related Virus) in old literature.

Incubation Period
The time it takes for symptoms of a disease to develop after infection. The incubation period in AIDS can vary from several months to many years. The average incubation period is believed to be about nine years.

KS (Kaposi's Sarcoma)
Many people with AIDS experience this cancer of the connective tissues in blood vessels. Pink, brown, or purple blotches on the skin may be a symptom of KS. KS lesions sometimes occur inside the body in lymph nodes, the intestinal tract, and the lungs.

Leukocytes
Commonly called white blood cells, leukocytes play a major role in fighting disease. lymphocytes are one subcategory of leukocytes. The two types of white blood cells often discussed in relation to AIDS are T-cells and B-cells.

Lymphadenopathy
Swollen lymph nodes.

Lymphocytes
White blood cells found in the lymph nodes and bone marrow. Lymphocytes are divided into two groups: B-lymphocytes, which produce antibodies, and T-lymphocytes, which are involved in directing the immune response.

Nonoxynol-9
A spermicide that has been demonstrated to kill HIV during laboratory tests. Sometimes it causes irritation and inflammation of mucous membranes.

Opportunistic Infections
Infections caused by organisms that do not normally cause disease in people whose immune systems are intact. In New York

State, the most common opportunistic infections indicating that someone has AIDS are PCP (Pneumocystic Carinii Pneumonia), Esophageal candidiasis, Cryptococcal meningitis, Mycobacterium avium complex, Toxoplasmosis, and CMV (Cytomegalovirus).

Oral Sex
Sexual activity in which the mouth of one person comes into contact with another person's penis, vulva, or anus.

PGL (Persistent Generalized Lymphadenopathy)

A phase of HIV disease in which people experience chronic swollen lymph nodes in several areas of their body. Generalized symptoms of HIV disease might also be present, but no major opportunistic infections have occurred because the immune system is still functioning relatively effectively. This phase of HIV disease has sometimes been called ARC.

PWA (Person with AIDS)
The PWA Coalition explains why many people living with AIDS prefer this term: "We challenge the label 'victim,' which implies defeat, and we are only occasionally 'patients.' We are people with AIDS."

Retrovirus
A type of virus that is able to insert its genetic material into a host cell's DNA. Retrovirus infections had not been found in human beings until recently. HIV is a retrovirus.

Risk Reduction
The process of adopting behaviors that reduce the likelihood that an individual will be exposed to HIV.

Safer Sex
Sexual activities that are not likely to transmit HIV. Safer sex involves sexual expressions in which partners make sure that blood, semen, vaginal mucus, and menstrual blood from one person do not come into contact with the other person's bloodstream or mucous membranes (vulva, vagina, rectum, mouth, nose).

Safety Skills
Risk reduction methods. Safer sex, not sharing needles, cleaning needles, and practicing universal precautions at work are all safety skills.

Seronegative
Testing negative for HIV antibodies (antibodies are not detected).

Seropositive
Testing positive for HIV antibodies (antibodies are detected).

Seroprevalence
The rate of seropositivity in a defined population. Suggests the rate of HIV infection for that population.

Spermicide
A contraceptive that works by killing sperm in semen. Some spermicides, such as nonoxynol-9, have also been demonstrated to kill HIV in laboratory tests.

T cell
One type of white blood cell. One type of T cell (T-4 Lymphocytes, also called Helper T cells) is especially apt to be infected by HIV. By injuring and destroying these cells, HIV damages the overall ability of the immune system to fight disease.

Treatment
There is no known way to remove HIV from the body once a person has been infected, or to cure AIDS by restoring all the abilities of the immune system after it has been damaged. However, many drugs and treatments are being used in experimental trials to determine how well they work against HIV infection and opportunistic diseases. Treatments fall into several categories: Antiviral treatments focus on destroying or inactivating HIV. Immunosupportive treatments attempt to rebuild or boost the immune system. There are also drugs used to treat or control the opportunistic infections and cancers that people with AIDS experience. Often all these types of treatment are used in combination.

Unsafe Sex
See "High-Risk Behavior."

Western Blot
A blood test used to detect antibodies to HIV. In New York State, this test is used to confirm the results of all positive ELISA tests. Their combined accuracy is 99 percent.

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